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1 FEDERAL TRADE COMMISSION

2 I N D E X

		Page
4	Mr. Berlin	3
5	Dr. Ginsburg	7
6	Ms. Mathias	26
7	Dr. Desmarais	30
8	Mr. Monk	38
9	Mr. Feldman	50
10	Mr. Lerner	64
11	Ms. Lee	114
12	Mr. Wu	115
13	Dr. Mazzeo	132
14	Mr. Pizer	144
15	Mr. Gabel	159
16	Mr. Dodson	170
17	Ms. Darling	183
18	Mr. Hyman	198

19
20
21
22
23
24
25

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

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3 MR. BERLIN: Good morning and welcome back to
4 the Department of Justice's and FTC's Joint Hearings on
5 Health Care and Competition Law and Policy. My name is
6 Bill Berlin. I'm with the Department of Justice. Today,
7 we begin our sessions addressing health insurance-related
8 issues. We'll continue this week through Friday
9 afternoon and then pick up again, I guess, two weeks
10 after that on May 7 and May 8 with more sessions on this
11 topic.
12 Generally, this week -- today and tomorrow
13 morning -- we'll be dealing with issues involving the
14 market downstream from insurers to purchasers of health
15 insurance. At the end of this week we'll be dealing with
16 the monopsony market, the purchase of provider services
17 by plans, and on May 7 and 8, we'll have some sessions on
18 MFNs, PHOs and countervailing market power, and all
19 that's in the agenda that's been on our website and I
20 think there are some handouts out on the table.
21 This session, as well as all the other ones,
22 the morning sessions will start at 9:15 and run until
23 approximately 12:15 and we'll be starting up at 2:00 in
24 the afternoon, including today, and that will run until
25 about 5:00.

1 And I'd also like to note, as we've been doing,
2 that interested parties may submit written comments in
3 response to this or any of the other topics and the
4 procedures and deadlines for doing so are on both
5 agencies' web sites.
6 At the outset, I'd like to thank our colleagues
7 at the FTC for letting us use this extremely nice and new
8 conference facility. Originally, we planned to have or
9 hoped to have these sessions in the Great Hall at Main
10 Justice, but due to, not surprisingly, recent security
11 issues, we just couldn't do that. And I'd also like to
12 thank our panelists for being with us here this morning
13 and all the future panelists in these sessions.
14 Let me just briefly describe this morning's
15 format and then we can get started. Before I do that,
16 though, I'd like to first introduce my co-moderator,
17 Sarah Mathias, from the FTC. She's not only my co-
18 moderator here today, but she's also been a key part of
19 the joint team from both agencies that have been putting
20 these hearings on, as most of you know.
21 We'll begin today with a framing presentation
22 by Paul Ginsburg. Paul is the President of the Center
23 for Studying Health System Change. I think this is an
24 appropriate place to note that, as most of you probably
25 have in your laps already, we have full biographies of

1 all our panelists out on the table. So, I won't belabor
2 their impressive backgrounds here today.
3 Dr. Ginsburg will provide us with an overview
4 of changing market trends and his conclusions based on
5 the Center's ongoing research on competition in health
6 insurance, and this should provide a backdrop for all of
7 our sessions going forward, not just today's or this
8 morning's session.
9 Then Sarah and I will probably have a few
10 questions for him to hopefully turn the focus a bit to
11 today's topic, which is defining product and geographic
12 markets for health insurance. Then we'll turn to
13 presentations by each of our panelists, exploring the
14 relevant economic and legal principles for defining the
15 relevant markets in a health insurance setting.
16 Once everybody has given their presentation,
17 we'll take approximately a 10-minute break, as we've been
18 doing, and then we'll come back for a moderated
19 roundtable discussion. Sarah and I will pose questions
20 to the panelists, but the panelists are also free to ask
21 questions of each other. A practice that we have also
22 been following that seems to be working is that if any of
23 you have a question, turn your tent or your placard
24 sideways and we'll try to take note and give you the
25 opportunity to comment on any of the issues that are

1 raised. And, again, as I said, we will end around 12:15
2 this morning.
3 Before we start with Dr. Ginsburg's
4 presentation, let me just briefly introduce the other
5 panelists and we'll ask them to speak in the order that
6 they're sitting at the table.
7 First we have Henry Desmarais, who's the Senior
8 Vice President of Policy and Information at the Health
9 Insurance Association of America. Dave Monk is an
10 Economist and Vice President with NERA, the National
11 Economic Research Associates, and one of his areas of
12 focus is antitrust.
13 Professor Roger Feldman is a Professor of
14 Health Insurance and Economics at the University of
15 Minnesota. And Art Lerner, is a partner with the law
16 firm of Crowell and Moring, practicing in the health law
17 field.
18 And I'd also like to note, as you see on the
19 agenda, that Barry Harris was going to be here with us
20 today; unfortunately, couldn't be here due to a last-
21 minute and unforeseen issue. But Sarah and I talked to
22 him on the telephone in our preconference calls and heard
23 him out on some of his views and we plan to try to
24 introduce and inject some of that into the roundtable
25 discussion.

1 So, without me jawing on any further, Dr.
2 Ginsburg.
3 DR. GINSBURG: Thanks, Bill. I'm really
4 pleased to have the opportunity to share our findings
5 with the Department of Justice and the FTC as they look
6 at competition in the health field.
7 I'm going to make three points today. One is
8 that we perceive some increase in insurance concentration
9 due to the withdrawal of weak competitors in some
10 markets. We also perceive that hospital market power has
11 grown more than insurer market power, in a sense this
12 leverage has changed in the past few years. And then the
13 final point is that the key to performance by health
14 insurers is really the direction that they get from
15 employers, and I think the problems we have now often
16 stems from the type of directions or absence of it that
17 insurers are getting from employers, their customers.
18 Briefly, this is my organization. We're a
19 research organization focusing on providing objective
20 information to policy makers and we're funded by the
21 Robert Wood Johnson Foundation. And what makes us
22 different from other Washington research organizations, I
23 believe, is our emphasis on health care markets, and
24 there's our web site.
25 Much or all of what I'm going to talk about

1 today is from our community tracking studies site visit
2 projects, which is now just about to complete the field
3 work for its fourth round. We do this every two years to
4 look at market changes and we visit 12 randomly selected
5 sites every two years. They're all urban areas with
6 population 200,000 and above, and I'm sorry this is
7 getting a little old when I say our recent visits, 2000,
8 2001. We have done 11 visits in 2002 and 2003. And we
9 tend to conduct a lot of interviews at each site. We
10 send a large team and we cover a broad cross section of
11 the leaders of local health care systems and we
12 triangulate the results, meaning we don't take anyone's
13 word for it. If Hospital A says something, we'll want to
14 compare it with what Hospital B and Insurance Company A
15 or B says about that particular development before we
16 have confidence in it.
17 Here are some thoughts of mine about the
18 framework to think about for analyzing insurer
19 performance. Insurers have responsibilities that are
20 beyond the classic insurance function of managing risk or
21 in health care, paying claims as well as managing risks.
22 They have to negotiate prices with the providers of
23 service. They have mechanisms to constrain utilization
24 of services, given the fact of the moral hazard and
25 health insurance. People who buy health insurance -- at

1 least the people who are paying for it -- usually want
2 insurers to do things to constrain the utilization of
3 services to get closer to what they value.
4 Also, today, insurers do disease and case
5 managements and perhaps in the world of tomorrow, they'll
6 be providing a lot of information for enrollees about
7 both prices and quality of care or even the effectiveness
8 of alternative medical procedures.
9 In a sense, health insurers are really one of
10 two intermediaries between consumers and providers. The
11 other intermediary is really the employer. And the
12 employer plays this role imperfectly, often, as an agent
13 in a sense, because employers can obtain health insurance
14 coverage for their workers at far more favorable terms
15 than the workers could get it as individuals. So, in a
16 sense, the employers, at least in the perspective the
17 economists have, are really spending the employees' money
18 in order to produce something that's worth more to them
19 than if they just paid them more in wages.
20 And we've seen, over the past, say, 10 or 15
21 years, some very sharp swings in the signals from
22 employers to health plans that in the early 1990s, the
23 signal from employers to health plans was we just have --
24 you have to save us money. Managed care looks promising,
25 do that. And employers weren't worried at that time

1 about if workers didn't like it, but then when health
2 care costs slowed, the economy boomed, labor markets got
3 tight, the signal was different and the signal was, don't
4 do the things the employees don't like. And this has
5 produced profound changes, not only in what health
6 insurers do, but in how the entire delivery system has
7 adjusted.
8 When we look at the 12 markets that we studied,
9 we perceived three categories that we can sort most of
10 the markets into, and I think this might be instructive.
11 I call them Type 1. There are four markets in our sites
12 that we'd call Blue Cross/Blue Shield dominant markets,
13 and I list the markets. All of the smaller markets have
14 this. And when I say dominate, I'm talking about, say,
15 roughly two-thirds of the commercial markets. And this
16 large market share has been long-standing. I'm sure it
17 goes back decades that these are Blue Cross areas.
18 In recent years in some of these markets, we
19 have seen unsuccessful entry by national firms. What I
20 mean is that national firms entered these markets, often
21 in the mid-'90s or a little bit later when insurers were
22 being very aggressive in entering new markets, and in
23 many cases, those national firms did not succeed, did not
24 get the share needed to be successful in the market, and
25 in recent years, they've been leaving some of those

1 markets. We also perceive in these areas informal public
2 utility pressures on plans. Plans are seen as very
3 important parts of the community and they have
4 responsibilities.
5 So, in Syracuse, the Blue Cross/Blue Shields of
6 Central New York, there's a major hospital in Syracuse,
7 New York that's been bankrupt for about two years, and it
8 seems, we have the sense from our last visit, that in a
9 sense that Blue Cross/Blue Shield is not bargaining as
10 hard as it could with that hospital because the community
11 would like to see that hospital continue and eventually
12 emerge from bankruptcy.
13 Actually, in Lansing, Michigan, and through
14 Michigan, Michigan Blue Cross/Blue Shield has actually
15 explicit regulatory responsibilities. It's actually a
16 real public utility. But in a recent dispute with a
17 major hospital in Lansing, the business community in
18 Lansing, both the automobile manufacturers and the United
19 Auto Workers, pushed Blue Cross hard saying, we don't
20 want you to give in, we're going to back you up.
21 And we also have similar examples in Little
22 Rock where Arkansas Blue Cross/Blue Shield thinks in
23 terms of community issues, perhaps doesn't use its clout
24 as much as it could if it were, say, maximizing profits.
25 It will do things that it perceives the community would

1 like it to do.
2 Another type of market is when the market is
3 concentrated into three or four major plans. Examples
4 are Orange County, California, Boston, Seattle, and
5 actually, in each of those three markets, and I don't
6 know whether it's critical to this model, there is a
7 long-standing local plan. Kaiser Permanente in Orange
8 County, Harvard Pilgrim Health Care in Boston and Group
9 Health Cooperative in Seattle. And, actually, in two of
10 those markets, probably contributes to this. There are
11 separate Blue Cross and Blue Shield plans which compete
12 with each other quite vigorously. Again, the
13 concentration is long-standing.
14 A third type of market that we encounter is
15 what we call the more fragmented markets, Phoenix, Miami,
16 Northern New Jersey. These markets are characterized by
17 rapid population growth, national employers and the
18 absence of strong local plans. In these markets, there
19 has been some increased concentration from mergers, and
20 national plans are important players in these markets.
21 So, this might be a context for thinking
22 through the different structures that can be encountered
23 in different areas.
24 Well, first, let me talk about what's been
25 happening with the plans relationships with hospitals.

1 Well, in some of the Type 1 markets, these smaller Blue
2 Cross/Blue Shield dominated markets, we've seen quite a
3 number of exclusive contracts between the Blue Cross/Blue
4 Shield plan and often the dominant hospital and sometimes
5 exclusive contracts between the lesser plans and the
6 lesser hospitals as well. These contracts seem to be in
7 decline now.
8 I can imagine they were very valuable when the
9 model of managed care was narrow provider networks and
10 recently was looking at Little Rock where Arkansas Blue
11 Cross/Blue Shield has long had an exclusive arrangements
12 with the dominant, I think it's the Baptist Hospital in
13 Little Rock and this actually seemed to have been a
14 business strategy because you see it all over the state
15 with exclusive arrangements in Arkansas. And given that
16 this was the best hospital to be able to keep your
17 competitors from offering that hospital in your network,
18 I could see, was very valuable. But with the change in
19 the shape of managed care, the emphasis on broad networks
20 -- I think these exclusive contracts are on the way out.
21 We've seen many situations, in my terms, and
22 I'm not an expert in this area, called bilateral monopoly
23 and they call it that way because you have -- you know,
24 the insurer needs all two or three hospitals in their
25 network and the hospital needs all insurers. Often, the

1 attitude of employers has been critical in the outcome of
2 these negotiations and these bilateral situations.
3 And I recall probably about three, four years
4 ago how when, in Boston, there was a dispute between
5 Partners Health Care and TUFTS Health Plan. I think
6 lawyers basically beat on TUFTS and said, you better keep
7 partners in your network or we'll drop you. Certainly,
8 that had something to say as far as the outcome of those
9 negotiations.
10 We've seen cases where employers now are -- see
11 the effects on their future premiums and are, in a sense,
12 encouraging the plans to push back to the hospitals, and
13 that's the basis of my point that employers matter in the
14 bilateral monopoly relationship as to who's going to
15 blink.
16 Also, some of the fragmented insurance markets
17 do face concentrated hospital markets and it's likely
18 that insurers are paying more as a result of that type of
19 structure.
20 What are the factors important to plan hospital
21 negotiation? Well, certainly concentration and that's a
22 real issue with the FTC and Department of Justice. I
23 would say some other factors which may not be as readily
24 apparent is the demand for broad networks, that when
25 employers or consumers insist on networks that all the

1 prominent hospitals are in, obviously, that gives those
2 prominent hospitals more power in negotiating with
3 insurers.
4 One thing that I hadn't thought about until
5 having done some interviews is that excess capacity is
6 very important and that's a big change from, say, the
7 mid-1990s when utilization was very much constrained from
8 managed care and there was ample excess capacity in
9 hospitals. There's a situation today where capacity is
10 much tighter. Part of that tightness is that some
11 facilities have been closed, facilities that seemed not
12 to be needed and perhaps were obsolete and, also,
13 utilization has been growing very rapidly in the last two
14 or three years, and this really makes a difference in
15 planned hospital negotiation as to whether the hospital
16 is worried about having a lot of empty beds if it can't
17 contract with a particular plant.
18 And I think this is what I mentioned before,
19 that there are community pressures on dominant health
20 plans and, actually one I didn't mention before, which I
21 should mention, is that in many communities, that are
22 pressures on the dominant health plans to discourage non-
23 hospital specialty facilities, such as a heart hospital
24 owned by MedCath. For example, in Little Rock, Arkansas
25 Blue Cross/Blue Shield will not reimburse care performed

1 in the Arkansas Heart Hospital.
2 In Lansing, Michigan, this goes back a few
3 years, there were some physician-owned ambulatory
4 surgical centers that were opened. Under pressure from
5 the employers and the union customers of Michigan Blue
6 Cross/Blue Shield, they would not pay for care in the
7 ambulatory surgery centers.
8 Sometimes the pressure actually comes from a
9 dominant hospital which, in a sense, will press the plan
10 not to pay for care in their competition, and sometimes
11 it comes from the purchasers, the people paying the
12 bills. But that's been a very significant issue with
13 dominant health plans in some sites.
14 There have been important developments on the
15 product side in recent years. Certainly, the trend now
16 is to have products with more patient cost sharing and I
17 would say that plans -- one of their competitive
18 challenges today is to innovate in benefit designs.
19 Certainly, consumer directed plans is one of the new
20 areas for innovation that many plans have pursued. I
21 used to never know what consumer-driven things were, but
22 now I know. Consumer-directed health plan, I believe,
23 has a personal savings account and a substantial
24 deductible. I think the field is finally settled on
25 that.

1 Other new benefit designs, tiered hospital
2 networks, one of the responses to loss of leverage with
3 health plans and, perhaps, a desire to direct enrollees
4 to more efficient facilities is within the network to
5 establish separate tiers and, in a sense, provide
6 financial incentives to direct enrollees to those
7 hospitals that are either less expensive or, perhaps,
8 perceived to be more efficient, better quality, et
9 cetera.
10 I would envision that we're going to see a lot
11 of sophistication in cost sharing. It's not just going
12 to be, you know, 20 percent co-insurance or this
13 deductible. I could see insurers differentiating co-
14 insurance by the service it's applied to, and sometimes
15 even having positive incentives. For example, free
16 diabetic supplies for those diabetes patients who enroll
17 and participate in the diabetes disease management
18 program that the plan is offering.
19 Another trend that we're seeing is a lot of
20 customization of products. Insurers have always
21 customized for large employers and they're customizing
22 for smaller and smaller employers. Not complete
23 customization, but often, a lot of different varieties of
24 things that say a smaller employer can choose.
25 A lot of emphasis on customer service and maybe

1 this is an aspect of you don't want the insurer to
2 interfere with too much care, but you want your employees
3 to get really good service.
4 Disease management and case management, these
5 are new areas and some companies are pursuing it in a
6 more sophisticated way. Interestingly, this is a risk of
7 entry that insurers face, because employers don't have to
8 hire their insurer to do disease management. They can
9 hire a disease management vendor. They can, in a sense,
10 pay separately for those services and when the employer
11 is self-insured, you know, they can benefit directly from
12 it.
13 You know, I think the whole pharmacy benefits
14 management industry could be seen as, in a sense, entry
15 into the insurance. There was a function that insurers
16 could have done, but, in a sense, they either willingly
17 or unwillingly lost it to specialized pharmacy benefits
18 management firms. So, there are, and I think always have
19 been -- mental health services has been another service -
20 - management service which can be carved out. A lot of
21 mental health is managed not by the primary insurer, but
22 by a specialized behavioral mental health service
23 management provider.
24 Some comments on recent merger activity in the
25 health insurance industry. Most of it that we've

1 perceived has been cross-market mergers and it's been
2 intertwined with conversions of Blue Cross/Blue Shield
3 plans to for-profit status. The stated reasons for these
4 mergers are to get better access to capital and to
5 achieve scale economies which presumably could come from
6 the use of information technology and marketing and the
7 same promotional programs and in-care management and how
8 to do it.
9 I think there are some additional factors that
10 often aren't mentioned. One is, in a sense, expand the
11 reach of strong managers. I would imagine that some,
12 say, Blue Cross/Blue Shield plans are ran a lot better
13 than others. And I've actually seen some of the mergers
14 in the past as really being a well-run Blue Cross/Blue
15 Shield plan taking over a not-so-well-run one, and then
16 seeing -- like in the corporate sector -- an opportunity
17 to run it better and gain from that. And, certainly,
18 with our local issue about CareFirst/Blue Cross/Blue
19 Shield, there's always this issue of, is it really being
20 done for the executives to either enrich the departing
21 ones or enrich the ones coming in.
22 What are the implications for competition from
23 these cross-market mergers of Blue Cross/Blue Shield?
24 Well, I think one thing is that to the degree that the
25 acquired plan becomes a stronger competitor, that

1 certainly could increase competition in the markets. On
2 the other hand, it may be a situation where you have a
3 Blue Cross/Blue Shield plan that, you know, fairly has
4 some real advantages and somewhat dominant. If you run
5 them better, they can be even more dominant and that
6 could reduce competition and lead to higher
7 concentration.
8 Premium trends is, I guess, one of the reasons
9 we focus on health insurance. And, you know, some of the
10 factors behind the very rapid increase in premiums,
11 certainly part of this is the insurance underwriting
12 cycle leading to wider margins at the moment.
13 You know, my best read on where we are, I guess
14 there are two ways to see where you are in the
15 underwriting cycle. You can either look at Wall Street
16 reports to see whether margins are going up or down from
17 insurers or the other thing is you can look at what's
18 happening in exit and entry from markets. And during the
19 stage of the underwriting cycle when premium trends are
20 exceeding cost trends, you expect to see exits from
21 markets rather than entry, and from our on-the-ground
22 sense at 12 sites, we are still seeing some exits, we're
23 not seeing any entry. So, by that indicator, the
24 underwriting cycle hasn't turned yet and, perhaps, isn't
25 about to turn that quickly.

1 Of course, probably the major factor behind the
2 rising premium trends has been rising utilization in
3 response, I believe, to the loosening of managed care.
4 Reduced authorization requirements, a very sharp decline
5 in the use of capitation to pay providers. So, there's
6 been a return to fee-for-service. And, actually, as
7 capitation has declined, it's probably also declined in a
8 way that's raised prices because some of the capitation
9 contracts that the providers hated, they hated them
10 because they agreed to a price that was effectively lower
11 than they thought. And so, part of the withdrawal from
12 capitation is a way to get the prices back up to where
13 they think they can get them and not be -- have this
14 distortion from, perhaps, their overly optimistic
15 expectations of what they could do to control utilization
16 that they're responsible to.
17 Easier access to specialists, you know, a major
18 change, throwing out the gatekeeper model. These are
19 some of the factors behind utilization rising.
20 Certainly, it's always important to mention the
21 most important driver of costs, both long-term and short-
22 term, is always new technology. Something that's very
23 difficult to get a handle on quantitatively. The
24 research on the role that technology plays in rising
25 costs really just looks at a residual and calculates it

1 in a residual. I just don't know if there's a way to
2 assess the impact of technology on costs other than doing
3 it as a residual, other than going, you know, condition
4 by condition, service by service. There doesn't seem to
5 be a way to do it in the aggregate.
6 Rising prices to providers has been not that
7 important share, but it is increasing and some of that
8 comes from the factors I mentioned before about hospitals
9 and, in some cases, specialty physicians having more
10 leverage vis-a-vis health plans. But other factors that
11 are important are shortages of nurses and other labor,
12 such as radiology technicians, pharmacists.
13 Now, when you look at BLS data, starting in
14 2001 you started seeing very steep wage increases for
15 hospital employees in the aggregate and presumably even
16 steeper for some of those groups.
17 Another thing that's more controversial among
18 economists -- and I don't know how Roger feels about this
19 -- but cost-shifting from Medicare and Medicaid. Many
20 people believe that when Medicare and Medicaid squeeze
21 their payment rates that, in fact, there has been some
22 ability to raise prices to private insurers that
23 hospitals had not pursued before, but in response to
24 lower Medicare or Medicaid payment rates, they will.
25 I think the outlook for Medicare is, you know,

1 relatively stable, perhaps slightly declining prices in
2 relation to cost. But, certainly, there are prospects to
3 sharp declines in Medicaid payment rates because of
4 states' financial difficultly.
5 What can turn the trend towards rapidly rising
6 premiums? Well, for one thing, a turn, the underwriting
7 cycle, will happen at some point and that will make some
8 difference. But I think the key thing is when employers
9 take an increased interest in cost containment and pursue
10 it more vigorously than they have in recent years.
11 Here are some policy implications. When the
12 performance of insurers involves more than margins, that
13 we want insurers to have more than margins that do not
14 represent excessive monopoly power, we want insurers to
15 innovate and to take steps and cut costs and also -- but
16 part of this, I think, is the nature of the signals that
17 they get and will get from employers.
18 Provider market power has grown rapidly in
19 recent years. Sometimes it's been caused by mergers;
20 often caused by employer insistence on broad networks.
21 And insurer market power, in its monopsony market, can be
22 a counterweight that's positive in some cases. And some
23 markets appear to have only limited prospects for
24 effective competition.
25 You know, think of markets that have dominant

1 Blue Cross/Blue Shield plans. It's probably very hard to
2 envision really effective insurance competition in
3 markets that have dominant hospitals. I think there are,
4 as I mentioned, informal pressures, at least in the
5 smaller communities often at work to, in a sense, move
6 these situations toward the outcome of a more competitive
7 direction, but it really is wise to start talking about
8 in these markets where the prospects for competition
9 aren't that great, what else can be done really to
10 protect consumers against paying prices that are too high
11 and not having the innovation and cost-cutting that we
12 associate with competition.
13 Thank you.
14 MR. BERLIN: I have, I guess, what is a
15 multiple compound question. If you'd rather stand or
16 sit, I'll throw it out there.
17 DR. GINSBURG: I believe I can see you from
18 here.
19 MR. BERLIN: Okay. My understanding from the
20 calls that we've had to the panelists setting up these
21 topics and reading some of the presentations is that
22 there are three dimensions, at least, to the market
23 definition issue. One is, is there a separate market in
24 the distinction between HMOs, PPOs, POSs, et cetera?
25 That's one. Two, the sort of self-funded versus fully

1 funded dichotomy, and third, the scope of the geographic
2 market.
3 And I'm wondering, based on your observations
4 regarding the managed care backlash, the proliferation of
5 the trend to broader networks, product innovation and
6 customization, do you see the lines -- you know,
7 addressing the first one first -- the lines between HMOs,
8 PPOs, et cetera, blurring in the last -- choose your time
9 frame -- the last several years? And then the same
10 question sort of on the self-insured/fully insured.
11 DR. GINSBURG: Sure. Well, you know, I think
12 from a customer perspective, the line is somewhat
13 blurred, or at least will be soon once we get past the
14 era that HMO is a dirty word, which, you know, is still
15 in a lot of media type discussion. But because the HMOs
16 have broadened their networks and, of course, they have
17 the POS version where you can get some coverage. One
18 distinction between HMOs and PPOs is the HMOs used to do
19 a lot more as far as managing care. Since they're doing
20 less, that makes them similar. So, yeah, I would say
21 they're probably pretty close substitutes now and I would
22 certainly think as both of them as part of a market.
23 Do you want me to get into the second and third
24 part?
25 MR. BERLIN: Actually, yeah, the second part as

1 well.
2 DR. GINSBURG: Sure. Now, the second part, you
3 were saying for self-insured?
4 MR. BERLIN: Well, do you see, again, the line
5 between employers that are self-insured versus those that
6 are fully insured as blurring perhaps for certain size
7 employers or any other criteria?
8 DR. GINSBURG: Well, yeah. I've, you know, for
9 a long time always felt that the distinction between
10 fully insured and self-insured was not very important for
11 many things. You know, in a sense, there's been this
12 very long-term trend of increasingly small firms moving
13 to self-insured status and a re-insurance industry having
14 developed to assist those small firms -- smaller firms in
15 becoming self-insured. And I think actually by self-
16 insured coverage being an option to more and more
17 employers, this actually broadens the range of
18 competitors in the insurance markets because now you have
19 the TPAs with the PPO rentals as perhaps a more effective
20 competitor to health insurance companies because there's
21 more of the market that they can potentially compete for.
22 MR. BERLIN: Okay. Sarah?
23 MS. MATHIAS: One of the questions that I have
24 is -- and it's more of are you beginning to see this --
25 is we keep hearing there's going to be an entry into the

1 insurance market from the Internet, the Internet sales of
2 insurance. Have you begun seeing that in any of the
3 cities that you have been looking at and how do you
4 foresee that affecting the competition between the
5 insurance companies and reaching the consumers and the
6 employers who are self-funded?
7 DR. GINSBURG: Yeah. Well, actually, I haven't
8 seen that in particular, but I would think that this
9 would be like consumer-directed plans that -- you know, a
10 few years ago when Definity Health became very visible,
11 you know, some people asked about what -- you know, is
12 this a threat to the insurance industry. And I said,
13 absolutely not because it would be so easy for an
14 insurance company to do what Definity is doing and, in
15 fact, that's what's happened. I think it was a year or
16 two ago, Aetna introduced a product and Humana introduced
17 a product.
18 And I would think the same would go for
19 Internet sales of insurance. To me, the real advantage
20 in today's market of an existing insurer is having a
21 provider network, you know, having the administrative
22 capability of processing claims and, you know, to me, the
23 Internet is really more of a threat to brokers than to
24 insurers that, in a sense, it could displace the brokers
25 or the brokers may actually just use the Internet as

1 their tool.
2 So, I think it's definitely going to have the
3 very positive effect of reducing selling costs, but I
4 don't see this likely to have an effect on competition in
5 health insurance because I just don't see it threatening
6 the major insurers.
7 MR. BERLIN: You, in your description of your
8 three types of insurance markets that you've used to
9 categorize the 12 total that you've looked at, in your
10 Type 1, the Blue Cross/Blue Shield dominant markets, as
11 you characterized it, you noted unsuccessful entry by
12 national firms, and I'm wondering to what extent you've
13 seen that phenomenon in your Type 2 or Type 3 markets?
14 DR. GINSBURG: Certainly, some of it. But they
15 -- say in a market like Miami, which I'm not sure that
16 I'd put in the thing because we have a couple of markets
17 that weren't clearly in one type or another. Certainly,
18 a market like Miami has had successful national entry,
19 United Healthcare, and it's had unsuccessful entry of
20 firms that left. So, yeah, I would say there has really
21 been a mix.
22 I would say, in recent years, though, that the
23 only -- the successful entry of national plans into
24 markets has come from purchasing hospital-owned health
25 plans, and now that the hospital-owned health plans are

1 mostly gone, I would not be surprised if we wouldn't --
2 certainly, in the short term, I wouldn't expect to see
3 much national plan entry. But then I have to remind
4 myself of what stage of the underwriting cycle we're in.
5 But I think that that actually -- the most
6 successful -- I mean, I think early on in my work we
7 would see entry by acquiring a smaller local health plan.
8 But I think the most successful ones have been acquiring
9 some of these large hospital-owned plans. It's really
10 striking that even though, you know, most people thought,
11 and I think correctly, that this doesn't make sense,
12 hospitals going into the health plan business, and they
13 will lose money and certainly many hospitals did lose
14 money. But there were some that actually were, you know,
15 successful enough. They weren't ragingly successful.
16 And that once it became clear -- often, it's not that it
17 became clear they shouldn't be in the business, but that
18 they needed the money for something else maybe to invest
19 in bricks and mortar in the hospitals.
20 So, some of these plans have reached
21 substantial enrollments and they fetched a very good
22 price because this was, you know, a very effective way
23 for a national insurer to enter a particular market. I
24 think Phoenix was one where one of the national plans
25 entered by purchasing a very large hospital-owned plan.

1 So, I think that's something that has been
2 important, but probably the opportunities are mostly
3 gone.
4 MR. BERLIN: Okay, I'm sure we could probably
5 continue following up with you for the rest of the
6 session, but I think to stay on schedule, we will move
7 along. I understand you're not going to be able to sit
8 for the subsequent panel discussion, so I'd like to thank
9 you again right now for your presentation and answering
10 these questions.
11 DR. GINSBURG: You're very welcome.
12 **(Applause.)**
13 MR. BERLIN: And next, Henry Desmarais, if
14 you'll give your presentation.
15 DR. DESMARAIS: Thank you very much. I'm going
16 to present from here. I have to say, I feel a little
17 naked sitting on this panel today without a law degree or
18 an economics degree, but I will try to soldier on.
19 I am here, obviously, representing the industry
20 that's under discussion. Our member companies do provide
21 the full range of health insurance products to about 100
22 million Americans, including the comprehensive medical
23 insurance, which is the primary focus of what we're going
24 to talk about today. But they're also in the dental
25 business and the disability and long-term care and

1 supplemental insurance businesses, as well.
2 I'd like to start by observing that we believe
3 that the health insurance market is both highly
4 competitive and highly regulated. I'm willing to
5 elaborate on both of those. According to a recent study,
6 the number of managed care organizations competing in
7 each of the top 40 major metropolitan statistical areas
8 averaged 14 plans. From a low of about eight plans in
9 the Buffalo, Niagra Falls and Pittsburgh MSA to a high of
10 41 competing organization in New York, northern New
11 Jersey and Long Island MSA.
12 In addition, in each of these areas, there was
13 an average choice of more than three different types of
14 products in each area creating a very diverse
15 marketplace.
16 As a result of the wide availability of
17 different health insurance products, 62 percent of
18 workers with employer-sponsored health insurance are
19 offered more than one choice of health insurance
20 products, and I think that also has a factor here in the
21 competitiveness, because they not only have choice among
22 plans, but even among the particular insurer might have
23 choice of various types of delivery vehicles.
24 A wide variety of plans offer different and
25 often multiple delivery systems. We heard Paul talk

1 about HMOs, point of service plans and preferred provider
2 networks or PPOs. There is still some old-fashioned
3 traditional indemnity products sold out there. Also,
4 while our primary focus may be the employer market, I
5 think we need to remind ourselves, there's a whole other
6 market out there of individual insurance. In fact, about
7 16 million Americans purchase their own health insurance.
8 That means they pay for the whole thing, they don't have
9 an employer subsidy.
10 From our perspective, it's important to realize
11 that there's really two distinct markets. There's a
12 group market for health insurance, as well as an
13 individual market. The two markets vary considerably in
14 terms of the economic, business and regulatory
15 considerations and we need to keep that in mind. I
16 should observe that our member companies are in both of
17 these markets and competing in both of these markets.
18 There are also important differences between
19 the health insurance markets for small and larger
20 employers. Hopefully, we'll get into more of that later
21 during our dialogue.
22 In addition, some employers choose to purchase
23 fully insured products while others self-insure, meaning
24 that they bear the insurance risk themselves. As Paul
25 Ginsburg said, they typically work with a TPA or a third

1 party administrator, which may be an insurer or may not
2 be an insurer, to process their claims and to do other
3 administrative functions for the self-funded plan.
4 Among the newest plan designs are what are
5 being called consumer-driven health care products and
6 that's interjecting a whole other array of competitors,
7 both in terms of benefit design and players that are in
8 the market. And, yes, I do believe that the Internet is
9 certainly adding to the competitiveness. An individual
10 consumer can now go there and determine who is providing
11 products in their locale, what the costs are and the
12 availability and so on. That surely must have an impact
13 on competitiveness.
14 To understand the current insurance
15 marketplace, it's important to recognize that insurers
16 are subject to intense government scrutiny of their
17 business practices. State insurance departments review
18 and approve policy forms. They perform market conduct
19 examinations and investigate consumer complaints. They
20 also regulate the form and substance of information
21 disclosures, insurers' investments, the discontinuance
22 and replacement of policies, claims payment practices,
23 appeals and grievances, and I could go on and on. In
24 fact, I could take my full 10 minutes just enumerating
25 the roles that state regulators play in the health

1 insurance market. Clearly, that's very different than
2 when we're talking about, say, grocery stores or any
3 other kinds of retail markets. This is a very different
4 kind of product.
5 Further, all insurers are subject to state
6 antitrust laws, rate regulation and other state and
7 federal insurance statute provisions that are enforced by
8 insurance regulators, state attorneys general, the
9 Department of Labor and the Department of Health and
10 Human Services. And even then -- and I think importantly
11 for purposes of this hearing, insurers are not free from
12 all aspects of federal antitrust laws and continue to be
13 explicitly subject to federal prohibitions against anti-
14 competitive practices such as price fixing, big rigging,
15 market allocation and so on.
16 In fact, there are very few business activities
17 that an insurer can undertake without having to consider
18 compliance with some existing state and/or federal law or
19 regulation. That pertains as well to mergers and
20 acquisitions. And while actions taken by federal
21 authorities, such as the Department of Justice and the
22 Federal Trade Commission against insurers for antitrust
23 concerns have not been common, that lack of activity is
24 not attributable to a lack of scrutiny. There are,
25 certainly, examples where there have been interventions

1 and required divestitures as a result of proposed mergers
2 within the insurance industry.
3 The other important point I want to make this
4 morning, for purposes of our talking about the market and
5 competitiveness, is that the degree of state oversight
6 that I've discussed always raises the possibility that a
7 state will adopt policies that have negative consequences
8 for its health insurance market, more specifically, by
9 reducing the number of insurers willing to do business in
10 that state.
11 Quite frankly, HIAA often finds itself in the
12 position of warning state officials that a proposed
13 course of action is likely to have a negative impact on
14 the insurance marketplace. Unfortunately, our words of
15 warning are not always heeded. But let me give you a
16 couple of examples. In 1994, the State of Kentucky
17 implemented a number of changes in their small group
18 insurance marketplace. They called them reforms. A few
19 years later, the State issued a report that noted the
20 following: The withdrawal from the market of 45
21 insurance companies. Anthem Blue Cross, the local Blues
22 plan, reported a $60 million underwriting loss. The
23 State Insurance Fund, Kentucky Care, lost more than $30
24 million.
25 Another example, in New Hampshire in 1995,

1 again, they made some changes in their small health
2 insurance marketplace. What was the result? At that
3 time, actually, there were 34 carriers that were
4 participating in that marketplace. As a result of the
5 reforms, the cost of health insurance coverage rose so
6 that by 2000, the market dwindled to about half a dozen
7 carriers who were left and also -- and, in fact, leaving
8 two carriers dominating the small employer market.
9 I'm happy to say, though, that most states
10 eventually recognize the harm that they are doing as a
11 result of their regulatory policies. And, again,
12 Kentucky and New Hampshire are perfect examples.
13 Last year, Kentucky legislators worked with the
14 health insurance industry in developing legislative
15 proposals to help alleviate the problems of the past.
16 And in 2001, the New Hampshire law makers, also working
17 with our industry, enacted reforms to begin the process
18 of repairing the damage done to their market. And the
19 market, I'm happy to say, is beginning to rebound.
20 Let me add a few more words in terms of market
21 definition considerations. It's certainly critical in
22 evaluating a given market that all relevant forms of
23 competition existing in that specific market are
24 carefully examined. I think I would echo many of the
25 points that Paul Ginsburg made in responding to your

1 questions. We have the PPO/HMO point of service that are
2 bleeding into one another so that the distinctions are
3 not as great as they might once have been. We certainly
4 have fully insured and self-insured products.
5 And I should make the following point:
6 Obviously, if I'm an insurer and I have an employer
7 customer, I have to be mindful of the fact that that
8 customer, at any time, can decide to become self-insured
9 and to assume that responsibility and hire a TPA, not
10 necessarily my insurance company, and that certainly has
11 to color the relationships between the employer customers
12 and the insurers and TPAs in which they do business.
13 Because likewise, a self-funded employer, can, at any
14 time, decide to purchase a fully-insured product.
15 So, again, I think, in looking at the
16 marketplace, you have to be mindful of that.
17 The next point I would focus on is the actual
18 patient or employee. Again, they have a role to play
19 here and, in fact, they have the option of refusing the
20 coverage that their own employer has offered, for
21 whatever reason, sometimes because of cost, they choose
22 not to take up that particular coverage. In any case,
23 when they have choices, they are also playing a role in
24 the competitiveness of the market.
25 Well, given all this variety and complexity

1 that I've discussed, defining a given market would
2 require an enormous amount of data that may be very
3 difficult to obtain and quantify. And, in particular,
4 obtaining information about the self-insured marketplace,
5 in terms of covered lives and costs and so on, may be
6 very difficult to do. But further, a self-insured
7 employer with plan participants in more than one location
8 may have a presence in various markets throughout the
9 country, adding further to the complexity of market
10 definition.
11 With that, let me stop and I look forward to
12 continuing this discussion later during the Q and A.
13 Thank you very much.
14 MR. BERLIN: Thank you very much.
15 **(Applause.)**
16 MR. BERLIN: Next we have David Monk.
17 MR. MONK: First, I'd like to thank the
18 Department of Justice Antitrust Division and the FTC for
19 holding these hearings and for inviting me here to speak
20 this morning.
21 Prior to June of 1999, there may not have been
22 much interest in a session dealing with market definition
23 in the health insurance industry. Fortunately, for those
24 of us on this panel, the Department of Justice's consent
25 with regard to the Aetna acquisition of Prudential

1 changed that.

2 Prior to 1999, there was no apparent

3 controversy. Up until that point, there had been no

4 enforcement actions taken by the antitrust agencies, so

5 the assumption was that the agencies viewed the markets

6 broadly. The issue is well-litigated, but uniformly, the

7 same conclusions were drawn. Health insurance markets,

8 at least statewide and possibly even national, product

9 markets include self and fully insured products and all

10 products, including indemnity PPO and HMO.

11 Now, as I understand it, the Department of

12 Justice began to test this proposition in 1998 with their

13 investigation of the Humana-United transaction. But that

14 deal cratered before they were able to complete their

15 analysis and the public did not know of their

16 investigation. When the Aetna-Prudential transaction

17 arose less than a year later, the Department of Justice

18 had another opportunity.

19 After a long, and at times contentious, battle,

20 the deal was approved with the consent in Texas. While

21 not setting a legal precedent, the significance of this

22 investigation and the consent is that it changed the

23 discussion. The complaint focused on an MSA level,

24 specifically naming Dallas and Houston, and on a product

25 market, it defined a fully insured HMO and HMO-based POS

1 plan market only.

2 As part of the NERA team working on behalf of
3 Aetna, this investigation into consent continues to play
4 a significant role in my thinking on these issues.

5 Since that time, there haven't been any court
6 decisions that I'm aware that affirm or dispute this
7 position, nor am I aware of any further agency actions.
8 There have, of course, been more transactions that have
9 been approved, some with considerable investigations, but
10 the Department has not publicly stated their conclusions
11 concerning market definition since the Aetna-Prudential
12 deal. However, my experience on more recent mergers
13 suggests that an MSA-based, fully insured HMO market is
14 still the Department of Justice's starting point.

15 So, without a lot of recent publicly available
16 history to frame my discussion, I will address each of
17 the components of the Department of Justice Aetna
18 complaint and the consent and what I believe is the way
19 to analyze the marketplace.

20 First, can an MSA be a relevant geographic
21 market? Managed care plans rely on physician and
22 hospital networks, which are inherently local and can
23 reasonably lead one to view the demand for health plans
24 as local. The licensing rules follow. While generally
25 to insure in a state requires only a single license,

1 plans typically must notify the Department of Insurance
2 of changes to provider networks before they can expand.
3 But that ignores supply substitution.
4 When measuring the extent of geographic markets
5 for health plans, it's also important to look at
6 geographic expansion or geographic supply substitution.
7 While the Department of Justice/FTC merger guidelines
8 generally do not apply substitution to market definition,
9 the ease and speed with which these plans can move from
10 one part of a state to another make insurance markets an
11 exception.
12 As I mentioned, all that is required for a plan
13 already licensed in a state to expand to another area of
14 that state is to contract with an existing provider
15 network and then market their new product. This means
16 that the expansion could occur with enough speed and,
17 therefore, constrain price under the merger guidelines of
18 a hypothetical monopolistic test.
19 To measure these effects requires an analysis
20 of the relevant regulations and a study to see the
21 expansion that has taken place. In the late 1990s, there
22 were many examples in many states where insurers rapidly
23 expanded services from one part of the state to the next
24 and the data showed that this expansion came at a very
25 low price.

1 So, can an MSA be a relevant geographic market?
2 I don't think it's likely. When the geographic expansion
3 is properly factored in, it's hard to imagine a state in
4 which an MSA could be a relevant market.
5 The second question is, do self-insured plans
6 compete with fully insured plans? Simply put, while
7 self-insured plans and fully insured plans may be
8 regulated different, they generally look the same to the
9 ultimate consumer. Most large national insurers and most
10 smaller regional insurers offer both fully and self-
11 insured plans, covering not just indemnity and PPO
12 products but also point of service and HMO products.
13 As has already been mentioned, there also are
14 local TPAs that are generally available to offer these
15 services and there are rental networks available to hook
16 up with the local TPAs to offer employers another option
17 for their insurance.
18 The analysis of win-loss reports from insurers
19 and switching reports from employers can tease out the
20 level of competition. But ultimately most employers are
21 left with a choice to fully or self-insure and they make
22 that decision based on a number of factors. They receive
23 guidance from brokers and consultants, when making their
24 choices, from all the available options, thereby leaving
25 me to conclude that both funding types are in the same

1 market.

2 The one exception to this may be small
3 employers who would be -- who may find it not
4 advantageous to switch to a self-insured plan. But this
5 segment of the marketplace is highly regulated and,
6 therefore, should not be much of a concern.

7 The final question is, do PPOs and HMOs
8 compete? This is the question that's garnered the most
9 attention over the past few years and the question where
10 the most empirical research was done. First, some
11 background. As we've heard, there are two types of
12 licenses. There are indemnity licenses and there are HMO
13 licenses. Indemnity licenses break out about 85 percent
14 PPO plans and HMO licenses are about two-thirds HMO plans
15 and one-third point of service plans.

16 Now, when we think about HMOs and PPOs,
17 historically, we've thought about them as being quite
18 different. The HMO, we think, traditionally is very
19 restrictive, requiring members to see only network
20 providers and requiring members to start with a primary
21 care physician or a PCP, and only after a referral and
22 approval can they go to see a specialist.

23 On the other hand, we think of PPOs as allowing
24 patients to see any doctor whenever they choose, even if
25 they have to pay a little bit extra to go to a provider

1 outside the network.

2 With regard to design, HMOs offer co-pays,

3 while PPOs have co-insurance and deductibles making the

4 out-of-pocket costs very different. And, of course, we

5 think HMOs cost much less than PPOs or indemnity plans.

6 But as Dr. Ginsburg has already said, these plan designs

7 have really begun to converge. There's open access HMOs

8 and POSs plans that allow members to go outside of the

9 network and, in some cases, see specialists without first

10 seeing a PCP.

11 Gatekeeper PPOs and exclusive provider

12 organizations require patients to first see a PCP, and in

13 some cases, do not allow members access to providers

14 outside of their network, despite their indemnity-based

15 license.

16 The benefit designs of convergence as well,

17 PPOs now offer co-pays. HMOs now have hospital

18 deductibles and use tiering to steer patients within

19 their networks. And not surprisingly, with the

20 convergence of the plan designs, there's been a

21 convergence in price.

22 In fact, in a 1998 study done by Mercer and

23 presented in their national survey of employer-sponsored

24 health plans, in the Midwest, the average out-of-pocket

25 cost for members of a PPO was $3,657. And by comparison,

1 the out-of-pocket cost for HMO members was $3,652,
2 virtually identical. While other areas were not that
3 close, the trend still seemed to hold. Analysis of
4 bidding documents, broker spreadsheets and planned win-
5 loss statements confirmed these trends laid out in the
6 Mercer study and show that the consumers do react.
7 Now, as I mentioned, the question of whether
8 HMOs and PPOs was empirically tested by both the
9 Department of Justice and the merging parties during the
10 Aetna-Prudential transaction. The DOJ concluded that the
11 best way to test the proposition that HMOs and PPOs are
12 in separate markets was to model consumer demand in
13 specific metropolitan areas, focusing first on Dallas and
14 Houston.
15 They employed a discrete choice modeling
16 technique based on a database that they were able to
17 construct for purposes of that investigation using their
18 subpoena power. They obtained data from competing health
19 plans, the merging parties, and also from employers,
20 which allowed them to study the choices made by employers
21 and employees.
22 From their modeling, they estimated
23 elasticities that were in the range of minus three. Is
24 that high or is that low? Well, based on margins, the
25 elasticity required for any firm or group of firms to

1 profitably raise price can be -- the margins can be used
2 to determine whether a firm or group of firms can
3 profitably raise price. This is known as the critical
4 elasticity.
5 If the estimated elasticity falls below the
6 critical elasticity, it can be inferred that a price
7 increase would be profitable and, therefore, the segment
8 being tested can be called a market.
9 With the health insurance industries
10 notoriously low margins, the critical elasticity in this
11 case would be high, and in this case, it was close to
12 minus six. So, with a critical elasticity well above the
13 estimated elasticity, the Department of Justice concluded
14 that HMOs and PPOs were in a separate market.
15 The Department of Justice actually, in putting
16 together this database, did an incredible job and
17 deserves a lot of credit for the approach that they took.
18 This is an incredibly difficult market, as was already
19 mentioned, to analyze because the data requirements and
20 the complexity of it. It's different from your typical
21 consumer product where the consumer walks into a
22 supermarket, sees a product and wants to buy it. Here,
23 you have the ultimate consumer and the person who
24 ultimately sells them their care, the provider, there are
25 two intermediaries in between and that causes the

1 difficulty.

2 There are two important factors. There's the
3 benefit design of the insurance plan as one, and the
4 second is the employee contribution strategy put forth by
5 the employers.

6 Now, we didn't have the ability to generate the
7 same database that the government had. So, in order to
8 test whether or not those two propositions which the
9 government was not able to easily put into their model,
10 we created a simulation. What this means is we created a
11 database that we knew the answer, we knew what the true
12 elasticity of the database was, and then we could run
13 tests to determine whether or not the estimated
14 elasticity of different models would, in fact, lead to an
15 estimate that's accurate.

16 So, we tested whether a proper model needs both
17 a benefit design and employee contribution included.
18 What we found was when either benefit design or employee
19 contribution strategy or both were omitted, yes, the
20 estimated elasticities were very low. However, when we
21 accounted for both factors, benefit design and employee
22 contribution strategy, the estimated elasticities were
23 close to the known elasticity of the simulated database,
24 which was minus 11.

25 Now, this doesn't say that the true elasticity

1 is in excess of minus six, but it says that the missing
2 data creates a bias towards challenging the merger.
3 In order to confirm this, we then looked at the
4 Mercer data that I already mentioned. Because Mercer is
5 a sister company of NERA, we were able to obtain the data
6 underlying their survey and further test the proposition
7 that benefit design and employee contribution strategies
8 are important.
9 The Mercer data is a survey of over 4,000
10 national employers. It contains data limited, but data
11 on benefit design and employee contributions. It does
12 not, however, give the ability to study employer choice,
13 but you do have the ability to study employee choice.
14 When using the same techniques that the
15 Department of Justice employed, we calculated
16 elasticities from these data that are consistent with the
17 conclusion that PPOs, POS and HMO plans are all in the
18 same relevant market.
19 We then used a technique called nested logit,
20 which is used to see whether potential markets grouped
21 together naturally and found that, in fact, HMOs and PPOs
22 do group together. Again, this wasn't done on national
23 data, so it doesn't test the proposition directly that
24 the government put forward in studying what was happening
25 in Texas. But, again, it does suggest that the important

1 issues of benefit design and employee contribution
2 strategies are very important and it leads me to conclude
3 that from the evidence that I've been able to analyze,
4 that HMOs and PPOs generally do compete in the same
5 relevant market.
6 As we've heard, since 1999, the world has
7 changed significantly. The managed care backlash has
8 continued to push these trends forward.
9 So, where are we now? First of all, Department
10 of Justice has definitely been asking the right
11 questions. The tools that I've discussed are the right
12 tools to use to analyze these questions. We need to
13 study the reactions of health plans, employers and
14 employees as the marketplace evolves. And, finally, any
15 analysis that takes place from here on out needs to
16 factor in the changing marketplace that is emerging due
17 to the managed care backlash. We're in a situation now
18 where the consumer is saying, I want more choice, I want
19 more access, and why is it the costs keep going up.
20 That's requiring the insurers to respond, and so, we have
21 to look at how they're being responded.
22 Thank you.
23 **(Applause.)**
24 MR. BERLIN: Thank you, David. Next, Roger
25 Feldman.

1 MR. FELDMAN: Now for something completely
2 different, I'm also going to talk about health insurance
3 monopoly, how to define the market, and as David said, we
4 all appreciate the opportunity to address you this
5 morning. Like him, I think the FTC and Department of
6 Justice are asking the right questions.
7 I'm going to start off with the Marshfield
8 Clinic decision to help frame my discussion. This is a
9 quote from the Court's decision as written by Richard
10 Posner, Chief Judge, Seventh Circuit. Posner opines
11 that, "It is well known that individuals and their
12 employers regard HMOs as competitive not only with each
13 other but with other forms of health insurance, such as
14 fee-for-service providers and preferred provider plans,
15 such that there is a single market for all forms of
16 health care financing."
17 Posner goes on to analyze HMOs which he regards
18 as relative up-starts in the market for physician
19 services. Kaiser's long experience notwithstanding.
20 Despite saying that HMOs and fee-for-service are demand
21 substitutes, Posner now backtracks. He says that many
22 people don't like HMOs because they restrict a patient's
23 choice of doctors and people fear they will skimp on
24 services. HMOs compensate for these perceived drawbacks
25 by charging a lower price than fee-for-service.

1 However, after saying that people perceive HMOs
2 and fee-for-service somewhat differently, he plays his
3 trump card. Even if fee-for-service were completely
4 different from the consumer's standpoint, they would
5 still be in the market, the same market, because
6 suppliers of services, that is the physicians who provide
7 a broad array of services, can easily convert from
8 producing fee-for-service to HMO medical care.
9 Notice that this is a relatively odd definition
10 of suppliers. I would think that the suppliers are
11 insurance companies and HMOs who might be able to offer a
12 new type of product. For example, the HMO could branch
13 out and offer a point of service product. I think the
14 emphasis on physicians misdirects our attention. It's
15 certainly true that analysis of the physician's market is
16 important, but this comes into play when considering the
17 supplier of an input to the insurance company, not the
18 supplier of the product itself.
19 However, this isn't the main problem with
20 Posner's analysis. The main problem is his opinion that
21 definition of a market depends upon supply as well as
22 demand substitution. Let's imagine for a moment that all
23 the firms making tanks and all the firms making
24 skateboards could easily switch and start producing
25 automobiles. Does this make tanks, skateboards and

1 automobiles part of the same industry? Of course not.
2 Supply substitution is not relevant for defining a
3 product market.
4 As clearly articulated by the horizontal merger
5 guidelines, market definition focuses solely upon demand
6 substitution factors that as possible consumer responses.
7 Supply substitution is important. It is used
8 to identify firms that participate in the relevant market
9 and it's used in the analysis of entry. But it is not
10 used to define the product market. Therefore, I will use
11 the guidelines approach because Judge Posner's economic
12 analysis is flawed.
13 HMOs are a separate product, according to the
14 guidelines, if a hypothetical monopolistic can impose a
15 small but significant and non-transitory increase in
16 price. I will argue that the evidence shows there are
17 different health insurance products and I will discuss
18 four extensions that need to be considered.
19 Here's the conventional wisdom, or if it isn't,
20 I think it should be. There are distinct products for
21 health insurance plans characterized by enrollees'
22 ability to see their own doctor, including the ability to
23 see specialist physicians without a referral and to use
24 any hospital recommended by a physician.
25 Judge Posner, however, was right about one

1 thing. People don't like managed care and they are
2 willing to avoid managed care plans by paying a premium
3 for the alternatives.
4 Along with co-authors Bryan Dowd, Matt
5 Maciejewski and Mark Pauly, I conducted a study of the
6 willingness to pay for different types of health
7 insurance plans among employees of large city and county
8 governments in 1994. We found that consumers were
9 willing to pay $34 per month more to belong to a fee-for-
10 service plan versus a PPO and their willingness to pay
11 for fee-for-service coverage versus HMO or POS, two other
12 alternatives, were significantly larger. Just to put
13 these premiums in perspective, the average family plan
14 costs possibly $500 a month. So, employees are willing
15 to pay up to about 20 percent of premium not to belong to
16 an HMO or POS plan.
17 Let's get down to some more detailed studies
18 which have actually attempted to estimate the price
19 elasticity of employee choice. Short and Taylor looked
20 at two types of choice between two fee-for-service plans,
21 and secondly, the choice of HMO versus fee-for-service.
22 They found that the price elasticity of enrolling in an
23 HMO versus FFS was less than half of the price elasticity
24 of choice between the two fee-for-service plans.
25 This means that employees are much more likely

1 to switch when their choice is two fee-for-service plans
2 and they are confronted by a small but significant
3 increase in price.
4 A $100 annual increase in the marginal net
5 price would reduce the market share of the more expensive
6 fee-for-service plan by 5.4 percentage points. But the
7 same increase in the HMO premium would reduce its market
8 share by 2.2 percentage points.
9 Next, along with co-authors Mike Finch, Bryan
10 Dowd and Steve Cassou, I estimated a nested logit model
11 of health plan choice for single employees and families
12 in 17 Minneapolis firms. The nests were distinguished by
13 freedom to choose your own doctor. We found that choice
14 within nests was sensitive to out-of-pocket premiums
15 controlling for benefit differences, by the way, whereas
16 choice across nest was much less premium sensitive. If
17 all the plans in a nest with 50 percent enrollment raised
18 their premiums by $10 per month, their market share would
19 fall by .04, that is it would fall from 50 percent to 46
20 percent.
21 In contrast, if a plan raised its premium, it
22 would -- and no one else followed, it would lose a
23 significantly larger proportion of its enrollment to
24 other plans in the same nest. So, the point here is that
25 choice among similar plans is very price elastic. Choice

1 between dissimilar plans is much less so.
2 There are a couple points that need to be
3 considered when you use studies like this to calculate
4 the possibility of monopolization. First of all, you
5 have to recognize that most health insurance is
6 subsidized, often heavily, by employers or Medicare.
7 Consumers use the out-of-pocket premiums to assess health
8 plan choice. That is, they're interested in how much
9 they have to pay from their own pocket, whereas health
10 plans use the total premium elasticity to maximize
11 profits. These observations suggest that the total
12 premium elasticity is greater than the out-of-pocket
13 premium elasticity because the total premium of the
14 health plan, which appears in the elasticity formula in
15 the numerator, is much larger.
16 Second, when analyzing the data for antitrust
17 purposes, the premium subsidy formula matters. A
18 percentage subsidy, for example, increases the price that
19 would be charge by a monopolist because each dollar or
20 $10 increase is shared with the employer and the
21 employees in some percentage.
22 In the extreme, a 100 percent subsidy implies
23 no limit to the price that a hypothetical monopolist
24 would charge. So, it's very important that you measure
25 and characterize not only the prices that are being

1 charged, but the type of subsidy formula that's in place.
2 I analyzed an actual HMO merger that occurred
3 in 1992 in Minneapolis when two large HMO plans, both of
4 which were in the restrictive nest, merged together. In
5 one firm where the two plans had 100 percent of the nest,
6 which approximates the conditions that the guidelines
7 want us to use, the simulated premiums rose by about 19
8 percent for both firms. This clearly meets the test of a
9 significant increase.
10 But it raises a key question. Will the firm
11 drop the merged plan? I'm going to come back to that
12 question in a few minutes because it suggests we have to
13 consider not only the employee's price elasticity but the
14 firm's decision to drop the merged plan.
15 Bob Town estimated a differentiated products
16 demand system for HMOs in the California HPIC, which is a
17 state-sponsored purchasing pool for small employers.
18 Town chose six hypothetical HMO combinations to generate
19 post-merger market structures. Two of those six
20 hypothetical mergers generated price increases greater
21 than 5 percent, although none of them monopolized the
22 market. This raises the possibility that there might be
23 differentiated products within the HMO nest.
24 Now, let's take a look at Medicare health
25 plans, which is an interesting market, different from

1 that of the employer health plan sector. Along with Adam
2 Atherly and Bryan Dowd, I found evidence of distinct
3 markets for Medicare health plans. We estimated a nested
4 logit model with fee-for-service and M+C branches --
5 excuse me, nests and M+C branches. We found that the
6 out-of-pocket premium elasticity for the M+C nest was
7 very small, on the order of .03. That means if all of
8 the M+C plans in a market raise their premium by 10
9 percent, they would lose three-tenths of a percent of
10 their market.
11 Notice that the total price elasticity is much
12 larger and the reason for that is because the government
13 provides a very large subsidy for most Medicare
14 consumers.
15 Tom Buchmueller also found a low fee-for-
16 service price elasticity for retirees of a multi-state
17 employer. So, this evidence demonstrates the existence
18 of separate and distinct markets within the Medicare
19 program.
20 Here are the four things I'd like to do if I
21 were to extend this analysis. First of all, we need to
22 look at the firm's demand for health plans. As I said
23 earlier, it matters whether a firm continues to offer or
24 whether it drops a hypothetical HMO that raises price.
25 If firms were perfect agents for individual workers, then

1 the firms' menu of health plans would just be the same as
2 the workers' choices. But because of transaction costs,
3 firms are imperfect agents for individual workers. So,
4 the total elasticity, that is, the total probability that
5 a worker is going to choose a health plan, is equal to
6 the sum of two elasticities, number one, will their
7 employer offer the plan, and number two, will they pick
8 it, conditional on it being offered.
9 And that means that worker level premium
10 elasticities provide an upper bound on health plans
11 market power. We have to consider two decisions and
12 they're both important.
13 Now, there are many empirical problems when you
14 try to estimate the firms' price elasticity of demand.
15 For example, what is the choice set? How many plans out
16 there in the community are really under consideration by
17 the firm? Unlike the employees' choice set, which is
18 defined for them, we don't know the answer to this
19 question without a detailed investigation.
20 Second, what are the relevant prices? List
21 prices won't work for health insurance. Firms get
22 different prices for multiple reasons including buying
23 power and different mixes of risk. So, the list price
24 that a health insurance plan posts is not necessarily
25 relevant for the firm's choice. One study that I found

1 does suggest that the price elasticity of firm choice is
2 greater than one. This is a paper by Mike Morrisey and
3 Gail Jensen, who estimated small firms demand for all
4 types of managed care versus fee-for-service and they
5 found a firm elasticity of around minus 1.9.
6 But this is a question that we really need more
7 work to answer. Will firms drop a plan if it raises its
8 premium? We really don't know the answer to that as well
9 as we need to know it.
10 My second extension is how do we deal with
11 quality change. The guidelines test for market power, I
12 believe, is incomplete because differentiated products
13 monopoly also involves changes in quality as well as
14 changes in price and the guidelines test, as far as I
15 read it, involves only changes in price. This is
16 probably a little more economics than you want to swallow
17 this morning, but if you assume that consumers have
18 different preferences for product quality, we'll just
19 call those consumers Theta-1 types who don't care a whole
20 lot about quality and Theta-2 types who have a much
21 stronger demand for quality.
22 Mike Mussa and Sherwin Rosen show that it
23 always pays a differentiated products monopolistic to
24 reduce quality sold to the Theta-1 types so they can
25 raise price to the Theta-2 types.

1 I have two graphs here -- I'm going to skip
2 over there -- which demonstrate graphically the Mussa and
3 Rosen argument and cut straight to their conclusion. The
4 differentiated products monopoly cuts the price and the
5 quality for people who have a low taste for quality. If
6 not many customers want that low quality product, the
7 differentiated products monopolist may drop it
8 altogether. So, that's a factor which is not considered
9 by the guidelines, in my opinion. Some products might
10 get dropped following a merger.
11 The Differentiated Products monopolist raises
12 the price for the types who prefer higher quality and
13 consumer surplus falls. The traditional guidelines test
14 of an increase in price is, therefore, incomplete. We
15 also need to consider changes in quality and the increase
16 in price must be quality adjusted.
17 My third extension is that I think we should
18 look at the effect of macroeconomic conditions on how to
19 define product markets. There's soft empirical evidence
20 which demonstrates that the price elasticity of demand
21 for HMOs depends on macroeconomic conditions. That is,
22 workers seem to be willing to pay a high price for fee-
23 for-service insurance during good times and during poorer
24 macroeconomic times, they tend to gravitate back to HMOs.
25 It suggests then that the state of the macroeconomic

1 economy might compress the price elasticity during good
2 times, pushing the products possibly into the same market
3 and then pulling them back apart again.
4 I'm not sure if antitrust policy, in fact,
5 ought to consider these fluctuations, but at the very
6 least, it matters when you measure it. The empirical
7 implications are that products definition could actually
8 depend on the stage of the business cycle and I leave it
9 as an open question because I'm not a lawyer in this
10 field, should the guidelines recognize this type of
11 product market expansion and contraction.
12 My fourth extension is self-insurance, which
13 has been mentioned a couple of times already this
14 morning. A self-insured firm bears risks and escapes
15 many, but not all, state insurance mandates. About half
16 of covered employees are in self-insured plans. That's a
17 good baseline number for you.
18 I am going to argue that the guidelines test
19 should be applied to self-insurance just like it's
20 applied to any other potential product market. That is,
21 if a hypothetical monopolistic could raise the price of a
22 self-insured product by a small, but significant, and
23 non-transitory amount, then self-insurance should be a
24 separate product from full insurance.
25 In deciding the answer to this question, I

1 think supply side substitution becomes important. I
2 would think that it's large for conventional and PPO
3 plans, smaller for HMOs and PSO plans. When I say -- I
4 think I made a mistake there, not in deciding that
5 question, but in evaluating whether or not there's ease
6 of entry into the markets, excuse me.
7 Let's take a look at firm self-insurance by
8 firm size. I think there are really three groups of
9 firms. First, these small firms, 3 to 199 employers,
10 basically aren't going to self-insure no matter what.
11 They're in the market for fully insured plans and they're
12 going to stay there. And big firms, 1,000 and above, are
13 only in the market for self-insurance. They see no
14 reason to go out and hire somebody to bear the risk for
15 them. It's really in this middle group, 200 to 999, that
16 the choice between self-insurance and full insurance
17 becomes relevant.
18 So, I think that when you're defining the
19 product market for self-insurance, you have to look at
20 the distribution of firms. If the distribution of firms
21 is centered on this type, then I think you have pretty
22 good reasons for believing that they actually are in
23 competition with each other. But if you found a market
24 which had only very small and very large firms, I don't
25 think there's much room for the switch to occur in that

1 market.

2 And, finally, when you consider whether or not

3 the firms who supply insurance can enter the market --

4 and, again, I want to emphasize this is not to be

5 considered a market definition, but it is a relevant

6 question when you want to ask who's participating in the

7 market and who enters it. I think it's pretty clear that

8 conventional and PPO sellers of insurance can easily

9 enter the self-insured market. You see, workers are much

10 more likely to be covered by self-insured conventional

11 and PPO plans.

12 On the other hand, HMOs and POS plans are much

13 less likely to enter the self-insured market. I think

14 that's because HMOs simply lack the data systems and the

15 claims paying ability to be self-insurers. In order to

16 make those significant investments, they would have to

17 compete against conventional and PPO firms that are

18 likely to already be there at much lower cost. So, I

19 think conventional and PPO firms can make this

20 substitution of POS and HMOs much less so.

21 My conclusions are that there are separate

22 product markets for health plans. Several issues need

23 more investigation. The firm's demand for health plans

24 is one of those. The effect of mergers on quality is the

25 second. Macroeconomic conditions may define products,

1 and finally, is self-insurance a product market.
2 Supply-side substitution is very important in
3 assessing the effects of health plan mergers. If I was
4 giving advice to an aspiring young economist and they
5 said, should I spend my career trying to define health
6 insurance products, I would say, no, it's already been
7 done, go look at supply substitution. That's where the
8 interesting questions are.
9 **(Applause.)**
10 MR. BERLIN: And our final presenter will be
11 Art Lerner and I think we will need a little time to load
12 up his presentation. So, talk amongst yourselves.
13 **(Brief pause.)**
14 MR. LERNER: I'll start by saying that I also
15 appreciate the opportunity to be here and thank the FTC
16 and the DOJ for having these hearings and giving us an
17 opportunity to talk and hopefully you'll get something
18 out of it. I've already gotten a lot of out it, which as
19 a reminder, picking up on Henry's theme, that I'm not an
20 economist. So, I noticed that during the last couple of
21 presentations.
22 I'll also mention that for those of you who
23 know me, I'm at a bit of a disadvantage because I had
24 what I was going to say, about 20 minutes of stuff in
25 about 10 minutes. But now I've picked up about another

1 half-hour of stuff I want to say, so I have 50 minutes of
2 stuff to say in about 10 minutes and we still don't have
3 the floppy up yet. There we are, all right. We're all
4 set.
5 Some of what I was going to cover we can skip
6 over quickly, but I will touch on it very briefly anyway.
7 And that is, when we talk about what a market is, I think
8 it's clear from the prior speakers we're talking about a
9 set of products within which a hypothetical profit
10 maximizing firm that was the only one there could impose
11 a meaningful and non-transitory increase in price and get
12 away with it.
13 Picking up on what Roger said, I had noted the
14 same thing, that according to the FTC merger and DOJ
15 merger guidelines, the market definition question focuses
16 solely on demand substitution factors, consumer response.
17 Supply substitution responses by other firms or even the
18 same firms, moving capacity or production into the sale
19 of those products, is not to be considered in defining
20 the product market, but is to be considered in assessing
21 effects, entry, et cetera.
22 I'm not sure how important that is
23 definitionally. That is the way the guidelines work.
24 Ultimately, the question, of course, is whether a merger
25 or conduct is going to have an anti-competitive effect

1 and you could argue that it's a little bit artificial to
2 draw these distinctions, but nonetheless, that is the one
3 that the guidelines draw.
4 So, what do you want to look at? You need to
5 look at buyers -- in testing, whether a hypothetical
6 market is a market, whether buyers will shift or consider
7 shifting purchases between products in response to
8 relative changes in price or other competitive variables
9 and a series of other questions we see there that are
10 posed in the guidelines. I think it's clear,
11 unquestionable, that HMOs and PPOs are in the same
12 market, okay? The question, I think, is really whether
13 there's a separate sub-market. That would have been the
14 words that we used a long time ago. If you assumed
15 hypothetically that the HMO offers the lower price in
16 exchange for lesser perceived quality in terms of access
17 to service or something like that, there would seem to be
18 no question that the price of the HMO product would pose
19 an outer bound on a price increase by a hypothetical
20 monopolist in the PPO market.
21 So, at some level, there is certainly a market
22 in which they all compete. The interesting question, if
23 there is one here, I suppose, is whether there is what we
24 used to call a separate sub-market, I suppose. We don't
25 use the sub-market anymore. Nobody uses it, but I

1 suppose we could.
2 I think it's important to keep an eye on the
3 ball and remember that the question is not, is there a
4 price difference between HMO products and PPO products
5 and all the other different kinds of products or whether
6 there are attribute differences between the products.
7 The question is, assuming a competitive equilibrium in
8 both and then the competitive equilibrium disappeared in
9 one of them so that then somebody tried to raise price,
10 would the change in relative price drive consumer
11 response back and forth between the segments. That's
12 really the question.
13 I don't think the question has changed that
14 much from 3, 4, 5, 6, 10 years ago. But one of the
15 questions has always been, well, if we define these
16 products, are these products in a separate market or sub-
17 market. Nowadays, it's getting increasingly hard to be
18 clear about what's the "product" you're talking about.
19 Just to pick on Roger for a second, just to use
20 him as an example. In one of his slides he referred to
21 managed care plans versus fee-for-service. In another
22 one he referred to whether or not you get to choose your
23 own doctor. I'm not saying these are wrong. What I'm
24 saying is when you then try to -- whatever you test in
25 your economic research, when you then try to -- in the

1 marketplace as a lawyer say, okay, then which firms are
2 in the market that we're -- which products and which
3 consumers are in the market that we're talking about
4 which ones are not, it is not so clear.
5 If you look at the different features that
6 people are buying, there's the insurance functions,
7 absent -- or somebody's doing it. There's access to a
8 network of providers in most cases. There's the UM, QI
9 and prior authorization programs. There's claims
10 processing. There's gatekeeper requirements and then
11 there's benefit design, in network or nothing, a
12 traditional closed panel HMO design. In network and a
13 reduced benefit if you go out of network. That would be
14 a POS or PPO type design. And then now, more commonly,
15 multi-tier benefit designs where you might have three,
16 four or even five different levels of benefits.
17 You have different configurations. You have
18 the all-inclusive vertically integrated products that
19 were an HMO most typically or a proprietary-insured PPO
20 like Aetna or Cigna or Humana or United might sell where
21 you're buying your insurance and your network from the
22 same company. You have a modular arrangement where you
23 have an insurance company who sells the insurance and it
24 basically rents a PPO network from a company that rents
25 that same network to a variety of different insurance

1 companies.

2 You have a model where the employer gets claims
3 processing from a TPA, operates on a self-insured basis
4 with a stop-loss carrier and there can be very low stop-
5 loss coverage.

6 I wanted to comment briefly on the fully
7 insured, self-funded issue there, for example. The law
8 firm that I used to work with, we were self-funded for
9 years and didn't know it until I became the benefit
10 manager within our 18-person law firm and found out,
11 well, gosh, darn, we were self-insured. So, when you do
12 these surveys that test a lot of small employers and say,
13 well, are you self-insured and you say, heck, no, we're
14 covered by the principal. Well, I was covered by the
15 principal and we were self-insured for years and didn't
16 know it because we had what was basically a self-insured
17 plan with a very low aggregate stop-loss that kicked in,
18 in which our experience, along with a lot of other small
19 employers, were pooled to determine how much the
20 aggregate stop-loss premium was. And through this
21 magical device, I am told we didn't have to comply with
22 some obscure benefit mandates from the District of
23 Columbia.

24 So, the basis distinction between being a self-
25 insured plan and a non-self-insured plan, I think, is

1 misty, at best.

2 I just finished a case last year involving a

3 PPO network in Indiana. For those who might want to read

4 it, it was the Gateway Contracting Services versus

5 Sagamore and you can go through that case and read about

6 all the different kinds of benefit designs and who had

7 what and the plaintiff's attempt to try to define a

8 product market of rental PPO networks, which is kind of

9 interesting.

10 Anyway, we'll go on with the show here. Let's

11 look at the different configurations of what's actually

12 out there today. You have HMOs, are they insured, sold

13 on an insured basis? Usually, not always. You can have

14 a self-insured HMO product.

15 PPOs, often sold on an insured basis; often

16 not, about 50/50, maybe even 60/40 self-insured.

17 Is there a network? Obviously, yes in both.

18 Is there a gatekeeper requirement in the HMOs? Often.

19 Less the case today when it used to be in terms of

20 product design. PPOs, sometimes. Unusual, but you have

21 some gatekeeper models on the PPO side.

22 Prior approval requirements. Before you can go

23 to the hospital or before you can go to see a specialist,

24 usually in the HMO, product designs but not always; PPO,

25 product designs often, sometimes.

1 Is there coverage for out-of-network benefits?
2 HMOs, increasingly common. Increasingly common. Look at
3 Kaiser. The way Kaiser has moved is sort of a classic
4 closed panel HMO product and look at the way they're sold
5 now. A lot of their business is now point of service.
6 In some states, it's mandated that they offer point of
7 service. PPO, of course, yes.
8 All of this suggests not that there aren't
9 differences in product design, but that you now have the
10 same companies offering all these different product
11 designs and consumers not being necessarily clear which
12 type of product you're getting simply based on the
13 license on which it was issued.
14 We were working on one merger investigation
15 where we were trying to measure market share and the
16 State Insurance Department sort of screwed things up by
17 writing a letter to our client and saying, oh, by the
18 way, these 123,000 people that you have, that you've had
19 under this PPO license, they really should be under the
20 HMO license given the way the product design is
21 configured. So, they jumped. It's not easy.
22 Now, you could still say -- all of the things
23 that Roger was testing, I think, are correct. In other
24 words, you need to measure whether within different
25 clusters or different types of designs for customers who

1 are interested in those types of designs, you could, in
2 fact, exercise some degree of market power due to
3 elasticity changes in all the rest. I am skeptical. I'm
4 skeptical. But I believe that those are all -- again,
5 all the right questions to ask.
6 Look at what United has done. United, who is
7 one of the leading national HMO companies, their most
8 typical HMO product now has no gatekeeper, referral
9 requirements, no prior authorization and a point of
10 service option. It sounds a lot like a PPO to me.
11 Then we've got EPOs, we've got ASO products,
12 we've got three-tiered benefits, we've got stacked
13 networks, we've got full replacement, carve-out networks,
14 dual option, triple option, minimum premium plans, low
15 threshold aggregate, stop-loss plans, capitated self-
16 insured plans, HMOs with indemnity PPO wrap products
17 around them, defined contribution plans, managed
18 indemnity -- I've never known quite what that one is --
19 and then blended premium programs.
20 All of this is not to say that it's not
21 possible, that the results that have been referred to
22 could mean that there are separate product segments for
23 antitrust purposes, separate sub-markets, separate
24 markets within this field. One of my concerns, though,
25 is that even if that were true, I don't think the normal

1 tools we have for measuring who's got what market shares
2 have much utility in that. In other words, if your test
3 was plans that require a gatekeeper, well, then looking
4 at HMO enrollment statistics doesn't tell you that.
5 Plans that have a higher -- a big differential
6 between -- you know, a 40 percent co-pay on going out-of-
7 network versus 20 percent co-pay on going out-of-network.
8 Licensing measures don't tell you that. And,
9 furthermore, of course, the supply side response
10 questions we're talking about are also important because,
11 in large measure, it's a lot of the same companies that
12 could switch over. I just like this slide. I was going
13 to use this for product market definition, just a little
14 change of pace.
15 What does the case law tell us? As the
16 previous speakers have indicated, all the litigated cases
17 have reached the conclusion that there is a broad market
18 definition. I agree with Roger that many of these cases,
19 the analysis is either thin or wrong-headed.
20 The old Ball Memorial case, there's a lot of
21 pontificating in some of these opinions and they totally
22 mush up the monopsony power and monopoly power get mushed
23 together in the Ball case. I agree with Roger's comments
24 about Judge Posner's comments in the Marshfield case.
25 There's a lot of messing up in some of these opinions,

1 but they all reach the same conclusion.
2 The DOJ settlement, of course, stands alone in
3 terms of federal government enforcement. There have been
4 a substantial number, though, of state proceedings, state
5 attorney general and state insurance department consent
6 decrees or orders dealing with HMO mergers. Of course,
7 under the State Insurance Holding Company Acts, they have
8 a presumption that a product line -- a licensed product
9 line is a market. That's built into the statutes that
10 they have to enforce and, of course, they have no
11 jurisdiction over self-insured products and have some
12 difficultly figuring out how to incorporate self-insured
13 products into their analysis.
14 Again, though, it is critical -- what I'm
15 talking about has been largely anecdotal from my
16 experience working with clients. I agree, again, that
17 the facts are critically important and I did not see the
18 results that the Justice Department came up with in
19 Aetna-Prudential and I haven't been able to actually see
20 the survey models that have been used and the research
21 models that have been used in some of the other studies.
22 I have been able to see the research models that have
23 been used by the imminently qualified economists that
24 work with us on various occasions, and in every case so
25 far, they usually, on a lot of these questions, end up --

1 you know, I know what the problems with the research is.
2 I would say all of this research to me can be
3 provocative, but I'm not sure how much it proves yet.
4 Who is in the market? Remember that the
5 question we've been discussing is what is the market and
6 David's comments about supply-side substitution -- Roger
7 addressed it by saying, yeah, well, that supply-side
8 substitution doesn't bear on product market definition.
9 Under the guidelines, that's right. But under the
10 guidelines, anybody who can substitute in is deemed to be
11 in that market. So, in the example about tanks, it would
12 be true that a tank manufacturer who could enter the car
13 market would not be viewed -- you would not, therefore,
14 say that tanks and cars are in the same market, but you
15 would, based on those factual presumptions, conclude that
16 tank manufacturers are in the car market. It's a little
17 bit odd to think about, but that's only because we don't
18 think of tank manufacturers as being able to make cars,
19 and vice versa. But if we were around in World War II we
20 would have seen that that's how it works.
21 What about narrower, even tighter, markets for
22 particular purchaser segments? For Medicare Plus Choice
23 enrollees for example? For Medicaid managed care? What
24 about small business? What about, as Henry referred to,
25 individuals? And Henry, of course, commented that he was

1 not either a lawyer or an economist, so I am sure -- I'm
2 sure he did not mean to suggest that the individual
3 health insurance market was necessarily a market for
4 antitrust purposes, but we'll discuss that later. That's
5 the situation where we all use the word "market" and
6 sometimes mean different things about it.
7 We don't have time this morning to go through
8 all of these individual ones. I just think the tests are
9 the same questions. You'd have to ask the same questions
10 about each of these segments to see whether you could
11 find it to be a distinct product market and then, of
12 course, you'd still then have to look at supply-side
13 substitution to see what other firms could jump in.
14 In some cases, such as Medicare Plus Choice,
15 the issue on concentration may be more a function of the
16 restrictions the government puts on who can get in the
17 market and why anyone would want to be in the market,
18 maybe more of a problem than concentration itself. And
19 that's it. Thank you very much.
20 **(Applause.)**
21 MR. BERLIN: We'll take about a 10-minute break
22 and come back a little after a quarter after to begin our
23 roundtable.
24 **(Whereupon, a brief recess was taken.)**
25 MR. BERLIN: I'd like to start off the

1 roundtable portion of this morning's session with a
2 question for Mr. Desmarais, who presented first and, I
3 guess, acknowledged, proudly I imagine, that he's neither
4 an attorney -- I'll speak only for attorneys -- or an
5 economist. But I'd like to get either his general
6 reaction to the things that he heard after he spoke or
7 specific reaction to any point before we move into some
8 more targeted questions.
9 DR. DESMARAIS: Well, there's been a lot of
10 material today and, honestly speaking for myself, you're
11 at a bit of a disadvantage when you can't really easily
12 see the slides as people are presenting. I guess it
13 shouldn't be a surprise that I was more comforted by
14 those whose comments suggested that the market includes
15 PPOs, HMOs, self-funded and fully insured; that, in fact,
16 this notion of distinctness really isn't there to a great
17 extent.
18 In particular, there's a couple of things that
19 Roger Feldman said that I sort of paused about. He
20 showed us a slide that looked at different size
21 employers. Now, the chart was arranged so 100 percent
22 wasn't the top. Seventy percent is where it cut off.
23 And so, you might have been misled to think that
24 everybody above a certain size was self-funded. But even
25 at the largest size employer he showed us, at 5,000

1 above, only 70 percent of them were self-funded. And I
2 think, more importantly, he was looking at a snapshot as
3 opposed to trend data for us.
4 So, I think that -- again, I think our members
5 would feel that the fully insured products and self-
6 funded products, to the extent those are options for
7 employers, and they can be options for employers even at
8 small size because of the availability of stop-loss
9 coverage, that that is part of the dynamic here that is
10 going on. And, certainly, it's certainly true that the
11 smaller employers tend to be those that are going to look
12 for fully insured coverage for a number of different
13 reasons. So, I think that's one point I would make.
14 I would also say that whatever the data are,
15 the real world certainly shows us that employers are very
16 concerned about health care costs, and so, they're not
17 interested in seeing monopoly pricing out there. And, in
18 fact, our companies regularly report that employers will
19 drop their coverage every few years because they're
20 looking for the lowest cost plan available in their
21 community.
22 And so, the whole issue of customer loyalty,
23 certainly among small employers and even individuals is
24 not there and that's, I think, a dynamic and the concerns
25 about cost are why the insurers are being creative in

1 terms of product design and why we're talking about
2 consumer-directed care and those other kinds of options
3 because of the pressures that employers are bringing on
4 the price side all across the marketplace.
5 And, certainly, the Census Bureau showed us,
6 the last time they took a snapshot, that coverage in the
7 private sector was actually falling and they were able to
8 document that much of that was in the small employer
9 market where, again, they're reacting. In fact, we've
10 got plenty of survey data that shows over and over again
11 that the primary reason that an employer decides not to
12 offer or to drop coverage is because of the price. And
13 so, I think that's an issue.
14 I guess not to just pick on Roger, I was a
15 little stunned by David Monk's comment that, well, you
16 know, the small employer market, that's a very -- it's
17 highly regulated and should not be much concern. Well,
18 in fact, as a consumer, I would disagree because if that
19 regulation increased the cost of coverage and reduces the
20 number of insurers selling in the market, we should be
21 concerned about it. And that's why I tried to give us a
22 couple of natural experiments -- so-called experiments,
23 where states actually had an enormous impact on that
24 aspect of the marketplace even though truly it is highly
25 regulated.

1 So, let me stop there so you can get a few more
2 questions in before the hour is up.
3 MR. BERLIN: Thank you. I apologize for mis-
4 speaking. I believe I called you Mister, instead of Dr.
5 Desmarais, while we're making light of people's
6 background.
7 Sarah?
8 MS. MATHIAS: The first question I have is for
9 David Monk. Professor Feldman recommended that one of
10 the things that we should take into account is the
11 quality and what happens with the quality and I was
12 wondering how would you address his statements regarding
13 that and is that something that we should be considering
14 when we're trying to define the market?
15 MR. MONK: I agree wholeheartedly with the
16 notion that quality should be factored in. When you look
17 at the choices that a consumer makes, their choices are
18 driven by the price that they see and driven by the
19 perceived quality of the product that they're looking at.
20 And so, one question is, is quality inherently analyzed
21 when you analyze price and I think in a differentiated
22 products market, the models are basically as seen.
23 In this industry, how do you measure quality?
24 The quality of an HMO plan has two aspects. One would be
25 how well does it do its claims processing and so forth.

1 That's really a concern of the providers. And how broad
2 are the networks? That's a concern of the insured.
3 Those, I think -- I think that gets to a part
4 of the reason why we see the difference in prices between
5 HMOs and PPOs, at least historically we saw those. As
6 Dr. Ginsburg mentioned, the networks are getting broader,
7 the prices are converging. So, I think, in a sense, we
8 may have -- certainly, we're trying to factor it in.
9 Whether we've done a good enough job or not, I'm not
10 sure.
11 MR. BERLIN: Dr. Feldman, anything you'd like
12 to say?
13 DR. FELDMAN: I think the analysis of quality
14 should be part of any potential antitrust proceeding. I
15 agree with David. It's very difficult. I want to just
16 mention quickly. It's probably a little bit easier to
17 study quality in the Medicare program than in private
18 insurance because in Medicare, we see variation in the
19 benefits that M+C plans offer. And some of these
20 benefits, like drugs coverage, are virtually universally
21 present in private insurance, but they may or may not be
22 present in Medicare.
23 Steve Pizer, one of the people from this
24 afternoon's panel, did a study where he showed that more
25 structural competition in the Medicare market is

1 associated with a higher probability than an M+C plan
2 will offer drug coverage. So, at least in this instance,
3 there's evidence which indicates that quality differences
4 are really important.
5 MR. LERNER: I want to just make a very quick
6 comment. I agree. But the only thing I would add is
7 that quality means different things in different contexts
8 and it's important to keep that in mind. When you look
9 at the price differential between a typical HMO product
10 and a typical PPO product, you can say that the price
11 difference is, in part, a function of the input costs
12 generated and that the consumer's willingness to pay for
13 the PPO instead of the HMO is because they perceive some
14 quality differential in terms of having a broader network
15 or having the ability to go out of network to get care,
16 et cetera, et cetera.
17 If you go to a different measure of quality in
18 terms of health outcomes or the quality of the actual
19 health care and health benefits that are provided, you
20 might get a completely different measure and you might
21 find that that HMO is actually delivering better
22 "quality." So, I just think when you evaluate all these
23 things, it's just very important to keep in mind what you
24 mean when you use the particular measure.
25 MR. BERLIN: Actually, I have a real long

1 question that requires a big wind-up, but I have a
2 shorter one that follows on this. That is, what is the
3 role of non-price factors and consumer switching between
4 insurance products and how can we factor in or how do
5 these things factor into a market definition analysis?
6 MR. LERNER: Because I'm not an economist, I
7 can give an anecdotal answer very quickly. I think if
8 you look at the experience of the CareFirst organization
9 here in the D.C. area recently when they had their big
10 public dispute with Children's Hospital, you saw a
11 tremendous amount of interest in that and you saw a lot
12 of enrollment loss to CareFirst with people switching
13 out. I don't have data on it.
14 In the federal program, of course, it's a
15 little bit distorted because -- well, people could have
16 switched out of -- well, actually, people switching out
17 of CareFirst could go either to another one of the fee-
18 for-service type employee association type plans or they
19 could join an HMO. So, someone could get data, I
20 suppose, and measure where did the Blue Cross members go
21 who quit CareFirst this December over that. But there
22 are all sorts of "perceived non-price reasons" why people
23 switch out of plan, network configuration being a
24 preeminent example.
25 DR. DESMARAIS: I'd add, though, what adds to

1 the complexity here is you have two levels of decision-
2 making. The first level is the employers, and
3 anecdotally, we often hear cost seems to be a primary
4 consideration for many of them just because this is just
5 part of the benefits and the expenses to handle. So,
6 once you reach the first threshold of what the employer
7 is willing to offer, then there's a second threshold for
8 the actual employee in terms of their selection and that
9 the whole issue about a pocket cost versus premium
10 contributions all come into play.
11 So, while quality is certainly -- and quality,
12 I agree, has to be viewed very broadly. It's sort of a
13 value. I mean, is my doctor in the network that that
14 particular plan is offering, et cetera. But what
15 physicians found, actually, is though they might have a
16 wonderful relationship with a particular patient, that if
17 the patient suddenly faced an added cost, that it didn't
18 take much additional cost before the patient said, I'm
19 sorry, I'm going to have to switch because there's a
20 lower cost plan and I'm going to take that lower cost
21 plan even though I can no longer see you under that
22 particular plan.
23 DR. FELDMAN: Again, drawing on the work of
24 Sherwin Rosen, economists view quality differences,
25 however you define them, as a compensating differential.

1 And the way we usually account for those is we add them
2 in our demand system as either shift or interaction with
3 some of the other variables in the demand system. The
4 way Bob Town did it, for example, is a fixed effect for
5 each one of the plans in the California HIPC. I've done
6 it by, more specifically, measuring the different types
7 of benefits that are offered. Very few people have done
8 it by looking at quality differences. That's the real
9 frontier here.
10 For me, the question is, when does its
11 attribute like quality become so important that it
12 actually differentiates the product and splits into more
13 than one product? In other words, we can look at quality
14 as a shifter in a demand system or we can look at it as
15 the thing which actually splits the product. And we
16 don't know how to do that very well.
17 MR. LERNER: I'd just mention that the FTC did
18 it in the Super Premium Ice Cream case, which is outside
19 the health care area, but there have been cases where the
20 enforcement agencies have drawn a distinction where
21 they've argued that, in fact, that divide has gotten so
22 clear that Super Premium Ice Cream is off there, separate
23 and apart from all the other contexts we've had.
24 DR. DESMARAIS: I mean, some things we do know
25 is that patients, by and large, are not making use of the

1 quality information that's available today, either the
2 employers aren't or even the patients, even though
3 there's a growing body of information. So, we have a
4 long way to go before people are even aware of what's out
5 there and are making use of it.
6 I guess the other complexity is when I select
7 my plan, I may not be thinking about what the best cancer
8 center is. But when I'm diagnosed with cancer, my whole
9 life changes. And so, there's all kinds of complexities,
10 I think, in this process that makes it difficult.
11 MR. MONK: I guess my limited addition to what
12 Roger said is that when you look at the benefit design --
13 and the benefit design is one place where you capture a
14 lot of the non-price issues in health insurance -- I
15 believe the number was something like -- Aetna had
16 128,000 different product designs among its employers or
17 the employer purchasers. So, you can't begin to factor
18 in all of those benefit designs.
19 What we were able to do with the Mercer data
20 was look at some specific issues. We were able to look
21 at, does a plan offer a psychiatric or mental health --
22 does it offer mental health? What kind of pharmacy
23 benefits does it offer? What level of co-pays? What
24 level of deductibles? What level of lifetime benefits
25 does an employee have? And to the extent we could, we

1 factored those in to our logit analysis to try to figure
2 out whether or not those do end up creating separate
3 nests and, therefore, creating separate markets.
4 MS. MATHIAS: My question goes more to the
5 geographic market. David had a -- one of his slides was
6 asking whether or not the MSA can be a relevant
7 geographic market and I believe at the end he was saying
8 that it needed to be a broader geographic market rather
9 than just the MSA, possibly the state. We earlier had a
10 telephone conversation where he gave the example that
11 Texas might be a relevant geographic market, but Rhode
12 Island might be maybe too small and that you'd include
13 some of the surrounding states as part of the geographic
14 market.
15 I'm a little confused on that because part of
16 your argument today, at least as I understood it -- and
17 maybe I didn't quite get it -- was the reason why
18 possibly the state should be the relevant geographic
19 market is because the ease of entry expansion was so easy
20 because you had already met so many of the regulations
21 and that wouldn't seem to me to be quite the same when
22 you're doing a greater several state geographic market.
23 If you could respond to that and then it looks like Roger
24 has a response as well.
25 MR. MONK: Well, I guess, first of all, there's

1 clearly a debate on the panel about whether or not
2 expansion is a supply substitution and, thereby, not
3 relevant in the market definition question. I'll put
4 that aside for answering your question.
5 In a state like Texas where Houston is an MSA
6 wholly subsumed by the State of Texas, Dallas is an MSA
7 wholly subsumed by the State of Texas, as is every other
8 MSA in the State of Texas, you can look at expansion, you
9 can look at demand within the state, and I'm not going to
10 say definitively that Texas is a relevant market, but it
11 certainly seems reasonable that one could reach that
12 conclusion.
13 If you take Rhode Island, which some might call
14 a suburb of Boston -- I can say that, my parents live in
15 Rhode Island -- if you take New Jersey, which has half
16 the state, part of the Philadelphia MSA and half the
17 state, part of the New York MSA, at that point, it's hard
18 to -- there, you're looking at demand substitution, I
19 think.
20 And if I'm putting together a provider network,
21 I'm going to need to put together a provider network that
22 covers Philadelphia if I'm looking to the insured that
23 live in New Jersey. Because many of those people who
24 live in South Jersey, in fact, work in Philadelphia. So,
25 I need to put the hospitals in there.

1 What will end up happening is then that the
2 insurers that are focusing on Southeastern Pennsylvania
3 are -- that may not currently offer products in New
4 Jersey have the same provider networks as the insurers
5 that are in New Jersey. And so, all they have to do is
6 get a license to operate in New Jersey and they can do
7 that. Getting a license is not that difficult if you're
8 a well-capitalized insurer. And, in fact, Independence
9 Blue Cross, which is a large insurer in Southeastern
10 Pennsylvania, in 1998 expanded into South Jersey and by
11 1999, was the biggest -- with a product call -- selling
12 plan called AmeriHealth, was the biggest HMO seller in
13 New Jersey. So, the expansion can happen very rapidly.
14 DR. FELDMAN: I think the notion that HMO or
15 health plan markets, whatever they are, are statewide is
16 nonsense, total nonsense.
17 Let me read the guidelines for you. Absent
18 price discrimination, the agency will delineate the
19 geographic market to be a region such that a hypothetical
20 monopolist that was the only present or future producer
21 of the relevant product at locations in that region,
22 would profitably impose at least a small but significant
23 and non-transitory increase in price, holding constant
24 the terms of sale for all products produced elsewhere;
25 that is, assuming that buyers likely would respond to a

1 price increase on products produced within the
2 tentatively identified region only by shifting to
3 products produced at locations of production outside the
4 region, what would happen?
5 So, what we've got to ask here is, if an HMO
6 with any region, or whatever our product is, raises its
7 price, would buyers switch to products produced outside
8 the region? Would firms introduce a health plan that's
9 located 10 miles away or would consumers switch to a
10 health plan that's located 10 miles away? That's the
11 kind of question we need to ask. And the answer is quite
12 clear, geography matters. It matters a whole lot.
13 I did a study where I looked at the choices by
14 employees in large Minneapolis companies, about 26
15 companies with 250,000 covered lives, and I found that a
16 five-kilometer increase in the distance between my home
17 and the nearest clinic, in an alternative, reduced the
18 probability of choosing that alternative by 12 and a half
19 percent.
20 Minneapolis is a very large metropolitan area.
21 Five kilometers is about three miles. That's a trivial
22 increase, guys.
23 MR. LERNER: Well, I agree with both of you
24 guys and I would only say, Roger, you sounded a little
25 bit like Judge Posner there with that last comment,

1 mushing the providers in with the insurance company as
2 being the question.
3 I think that -- what I was trying to say before
4 is that the guidelines create this discrete border and
5 they say you define the product market by measuring
6 consumer response. And I would agree, if you take
7 Roger's hypothetical in the purest sense, that people who
8 live in Northern Virginia, or an employer based in
9 Northern Virginia, cannot buy an insurance product from
10 an insurance company that's licensed only in Maryland and
11 not licensed in Virginia.
12 So, by definition, therefore, in that sense,
13 you can say that the consumers of a product in Virginia
14 can't buy a product from someone who's not licensed, nor
15 can they buy an HMO product from an HMO that's only
16 licensed in Richmond and not licensed in Arlington.
17 But the antitrust analysis, when you're
18 actually doing an investigation, doesn't go in these
19 little clumps, like, well, let's do the product market,
20 and we'll spend a year doing that and now let's do the
21 competitive effects analysis. If, in fact, as David was
22 saying, the companies that operate in Montgomery County
23 could, in a minute, start selling HMO coverage in
24 Arlington County, Virginia, then whether you viewed
25 Virginia as the market would not be particularly relevant

1 to the question of who are the competitors in that
2 market. You could consider the plans in Montgomery
3 County to already be in that market.
4 And that raises the question that Roger and I
5 were talking about during the break, which is, how do you
6 then measure market share, which we haven't talked about
7 at all because today's discussion is about market
8 definition. If Barry Harris were here, he would say that
9 absent exclusive contracts with the providers or absent
10 some telling barriers to entry in health insurance, you
11 ought to assign everybody the same market share because
12 today's market share is no indication of what tomorrow's
13 market share is going to be, and he would find some
14 words --
15 DR. FELDMAN: I say nonsense.
16 MR. LERNER: And he would find some words in
17 the guidelines to support that and Roger would say
18 nonsense.
19 DR. FELDMAN: I am not disagreeing that entry
20 into a geographic market might be easy. In fact, entry
21 is a lot easier if you're already licensed in the same
22 state. We found that an HMO that operated within a state
23 can easily go into cities within that state where it's
24 not already present. An HMO going from one state to
25 another is a trickier question.

1 But I want to make it clear that we should keep
2 these questions very separate and distinct in our minds.
3 What is the market? How easy is it to enter? Who are
4 the participants? What are their shares? They're all
5 distinct questions.
6 MR. MONK: I guess I would argue that it just
7 isn't that distinct, and this is piggybacking on what Art
8 said. If I, as an insurer, can quickly offer service to
9 people who live in Miami, even though I currently only
10 have a plan that's in Orlando, then the employee looking
11 for who they're going to buy when -- it's true, they
12 cannot currently choose that plan from Orlando. But if
13 that plan from Orlando -- if there was one hypothetical
14 monopolistic in Miami and that hypothetical monopolist
15 was considering raising price, it seems to me it would
16 have to consider the fact that that plan from Orlando
17 could jump in and immediately take away their share and
18 they do not want to upset their customer base for one
19 year's worth of profits.
20 Therefore, it would seem to me that you have to
21 consider the fact that from the hypothetical monopolistic
22 test, in that case, if the speed of entry is that quick,
23 it does, in fact, constrain a hypothetical monopolist
24 and, therefore, I think it should be considered as
25 passing the hypothetical monopolist test.

1 MR. BERLIN: Henry, do you have any reaction to
2 the comments?
3 DR. DESMARAIS: Well, I'm truly getting a
4 little confused because, like Art, I'm sort of agreeing
5 with -- I think you have to look at the facts. We seem
6 to want to focus on an HMO as if they're the only game in
7 town and anyplace in this country and if they sneeze,
8 somehow it has this monumental effect. I mean, quite
9 frankly, most of our members are in multiple states.
10 They're already competing and they may not have huge
11 market share in some places, but they're there. They're
12 selling product, they're available. So, I guess there's
13 a great deal of competition. There could be more in some
14 places, certainly.
15 But I guess I'm having a little trouble when we
16 focus so narrowly on this one HMO and we want to make an
17 issue out of that when, in fact, the employers in that
18 area and even the employees and individuals there, have
19 other options within that geography. What they're
20 looking for, I think, is health benefits. And if they
21 can obtain them in a variety of ways -- I'm not sure I'm
22 following the issue in the same way.
23 I'm not so cavalier about this, you know, well,
24 it's just a license, anybody can get it because our
25 members dutifully choose, make business decisions, they

1 will not do business in State X because the regulatory
2 climate is bad, the mandates are bad. There are a whole
3 range of issues that determine whether they will enter a
4 market. So, it's not automatically, oh, well, they'll
5 come. But it is a business decision and certainly
6 there's customers there, you know, they can certainly do
7 the things they need to do to get a network and those
8 sorts of things.
9 MR. BERLIN: You've given me a nice segue into
10 the question that I want to ask anyway, and that is,
11 we've been treating, in this discussion, I think, by
12 necessity given the format here, the issue of market
13 definition as sort of a one-size-fits-all, but I think
14 what we're starting to realize is that it may vary by
15 geography and it may vary over time. And that's my
16 question and I'll throw this out to anyone or everyone.
17 Would your definition differ by geographic market to
18 begin with? Picking up on your comment on good times,
19 bad times, how about a rich MSA versus a poor MSA.
20 DR. FELDMAN: Yeah, I --
21 MR. BERLIN: Let me just throw out my whole
22 long-winded question. The other one is on the time
23 continuum. Are your definitions, your analysis, your
24 motive defining it, different today than it was for five
25 years ago, say at the time of the Aetna-Prudential merger

1 different from eight to ten years ago in Marshfield
2 Clinic and U.S. Health Care, and will it likely change in
3 the future with -- due to the ebb and flow of the
4 underwriting cycle and maybe the managed care backlash if
5 we're going to see that and rising costs and whatnot?
6 So, I'll turn to my right, I guess, to begin.
7 DR. FELDMAN: I guess I grabbed the microphone
8 first. What's the Smith-Barney commercial, one client at
9 a time? Unfortunately, I think antitrust cases have to
10 be done one at a time. I have a lot of experience
11 interviewing employers in different markets. One of
12 those is Portland, Oregon where we found that even large
13 employers in the Portland market just don't want anything
14 to do with self-insurance. It's virtually a fully-
15 insured city for reasons that are not entirely obvious to
16 me. So, if I was doing a market definition and a case
17 was in Portland, Oregon, self-insurance is the issue,
18 let's say, I'd have to come to a different conclusion
19 than I would in some other city. I don't like to say
20 that, but I'm afraid that's how I would recommend doing
21 it.
22 DR. DESMARAIS: I'll be short; I don't disagree
23 with that.
24 MR. LERNER: I also agree and I would just
25 mention a couple of observations. One is when the first

1 HMO was established under the -- it wasn't the first HMO
2 but the first HMO that was established under the HMO Act
3 of 1973 and it started to do business wherever it started
4 to do business, you could say, well, it was the only HMO
5 and it had all these different attributes and it was a
6 very clear distinction. But if you said, well, who are
7 you trying to steal business from, it was pretty clear
8 who they were trying to get business from. It was from
9 Blue Cross and the indemnity organizations.
10 Later, you could go through a period of sort of
11 the HMO heyday and you could look at HMO planning
12 documents, if you got your HMO planning documents, and
13 you'd read who they -- and they would only be measuring
14 the market share of HMO competitors. And I would go to
15 them, to the senior executives, and I would say, well,
16 you know, you're being investigated by the government
17 here and all your planning -- and we're saying that
18 there's these broad markets and all your planning
19 documents only measure the market shares of other HMOs.
20 And you'd find out, well, why is that? Well, it's
21 because only HMOs report their data.
22 So, for a long time, the only data you'd ever
23 see was HMO data because there was no other data. So, I
24 think a lot of these things, I agree, you have to look at
25 the case you're dealing with and figure out what makes

1 sense. Obviously, if there's some irrational consumer
2 preference -- lawyers might say it's an irrational
3 consumer preference, economists generally would say,
4 well, it's a consumer preference, so it's a quality
5 factor. So, if the employers in Portland don't want to
6 be self-insured, it must be because self-insurance isn't
7 good in their way of thinking of things and, therefore,
8 it's different.
9 So, I think you do have to look at these
10 differences. But I don't think you can go for this
11 notion that there's -- you have to look at each situation
12 tempered by some sense of anomalies about that local
13 market that if the price went up, maybe they'd change
14 their mind.
15 MR. MONK: I was just about to say the same
16 thing, just on your point about the data. The data
17 aren't just HMO data, they're just fully insured HMO
18 data.
19 I think one has to look -- when you're looking
20 at a specific market, you do have to factor in what the
21 characteristics that are in that market at that time and
22 whether the characteristics changed because there was a
23 change in -- either the market was currently in balance
24 or out of balance. Let's take, for example, Texas in
25 1998. Almost all of the insurers were losing money.

1 Almost all the fully-insured HMOs were losing money. If
2 you asked a PPO provider at that time, would they ever
3 consider operating an HMO, the answer would be no.
4 However, if the HMOs had been making money,
5 would a PPO consider operating an HMO? The answer is
6 probably yes. So, you have to factor that in.
7 So, not knowing what's going on in Portland, it
8 may be the case that the reason why nobody wants to go
9 self-insured in Portland is because the products out
10 there are great and nobody has any interest in anything
11 other than that. But if that were to change, an
12 important question has to be, would people switch? And
13 you can look at history of other areas to try to figure
14 out whether or not if Portland were to change, things
15 would change.
16 MS. MATHIAS: I have a question that I'll throw
17 out first to Roger and then see if anybody else wants to
18 respond as well.
19 I've heard from various people, not necessarily
20 on this panel, but I think it's also come out on the
21 panel, that it's very difficult to define HMO versus PPO
22 and I was wondering, as you seem to have a clear
23 difference between the two, how much managed care is
24 required for it to fall into the HMO category? I guess
25 that's my question. How much managed care is required

1 for it to be an HMO? First, Roger?
2 MR. BERLIN: Do you mean for licensing
3 purposes?
4 MS. MATHIAS: Licensing purposes.
5 MR. BERLIN: Or for market definition purposes?
6 MS. MATHIAS: For market definition purposes is
7 what I'm going to do first for Roger and then --
8 DR. FELDMAN: I'm glad I wasn't asked the
9 licensed purposes question. I think that question
10 deserves a multi-part answer because it really gets to
11 the heart of what we've been discussing this morning and
12 you know my view, that there is a product continuum and
13 you could think of one end of the continuum -- in fact,
14 the slide that David put up earlier -- as being the
15 conventional fee-for-service insurance, and the other end
16 being the pure staff model HMO. And, originally, that
17 was all there was. There was a big empty space in the
18 middle. Lately, the space has been filling up with all
19 of these hybrids. Recognizing that as a fact, however,
20 is not the same as concluding that all products are
21 equally close substitutes.
22 In logic, if A is better than B and B is better
23 than C, then A is better than C. But in product
24 substitution, A and B can be substitutes, B and C can,
25 but that doesn't mean that A and C are. So, I still

1 think there is room for multiple products along that
2 continuum.
3 The way that you define them is back to the old
4 Smith-Barney way. You work at it. For example, Ann
5 Royalty and Neil Solomon did a study of employee choice
6 at Stanford University. The question there is whether
7 PPOs competed with POS plans, which are the hybrids with
8 some degree of choice that HMOs offer. There, they
9 concluded that POS and HMOs were, in fact, close
10 competitors. You have to -- I'm just going to give you
11 the economist's answer here. You have to go out and look
12 at the substitution between these different types of
13 products.
14 While price differences don't necessarily mean
15 there are different products, I think that price
16 differences among these options are interesting and
17 important. For example, HMOs are still about 20 percent
18 cheaper than conventional plans. David, I don't agree
19 with your evidence, and it might be right, but it was,
20 first of all, 1998 and, second, selective to one region.
21 According to the latest Kaiser Family Foundation survey
22 of national employers, the average difference between
23 HMOs and conventional plans is still close to 20 percent.
24 Now, there's got to be something different about those
25 plans or else they couldn't charge 20 percent more for

1 the fee-for-service plans in equilibrium. It doesn't
2 necessarily mean they're separate products, but it
3 certainly means that they are compensating along some
4 dimensions that are still important to consumers.
5 MS. MATHIAS: David?
6 MR. MONK: On the price issue and the cost
7 issue, the -- it was one region, it was 1998. The Mercer
8 studies -- Mercer has done this study every year for at
9 least the last 10 or 12 years. Their current 2002 study
10 says that, in fact, the converging trend continues. It
11 was just in the Midwest, although the evidence in the
12 southern region was virtually the same as that in the
13 Midwest. The Northeast, for some reason, there are much
14 broader differences in price. But I don't know that you
15 can -- I don't think that you can look at that difference
16 in price, and Roger just said, you can't just look at
17 that difference in price, and absent any other
18 information, conclude whether it's one market or whether
19 the same market or not.
20 But I think the evidence that I've seen does
21 seem to suggest as the products have -- the lines have
22 blurred, the prices have converged and that certainly
23 should be factored in.
24 MS. MATHIAS: I have a quick follow-up question
25 just as to those two surveys. Earlier somebody said that

1 you cannot -- you have to look not at the list prices,
2 but at the actual prices that are being negotiated and I
3 was wondering if either of you know whether those two
4 studies that you're referencing, are they looking at the
5 list prices or are they actually looking at what the
6 negotiated price was when all was said and done at the
7 end of the day.
8 DR. FELDMAN: These were actual prices. My
9 comment was meant in a slightly different context. If
10 you're a firm and you're paying $200 a month and I'm a
11 firm and I want to buy the same product, that doesn't
12 mean that I'm going to pay $200 a month. I might be able
13 to negotiate a better deal. I might have healthier
14 employees and so on. But the prices that I'm referring
15 to are actual prices that are asked of companies that
16 offer the different products.
17 MR. MONK: And that may well be one of the
18 differences between why Kaiser and Mercer get different
19 results. The Mercer numbers are not prices, they're out-
20 of-pocket employee expenses. So, it's factoring in both
21 what the employee has to pay as a contribution out of his
22 paycheck, but also the co-pays and what he pays for
23 deductibles and all that. And when you factor all those
24 things in, the prices -- that's the price that Mercer is
25 looking at.

1 DR. FELDMAN: Gee, that would make the HMOs
2 even cheaper because they still have less cost sharing.
3 MR. BERLIN: Changing gears here a little bit,
4 Dr. Ginsburg first highlighted what I think he called the
5 key role of employers in these issues and I think several
6 of you, Roger, you, in particular, I remember followed up
7 on that point. And I'd just like to get, you know,
8 perhaps starting with Art and Dave, your reaction or your
9 view to the role of employers in defining health
10 insurance markets, particularly given their role as an
11 intermediary between the plan and the consumer and the
12 patient, and also now that we're also hearing things
13 about, you know, consumer-directed plans, maybe let's
14 bring this back in that direction. So, what are your
15 views on that?
16 MR. MONK: When I was referring in my talk to
17 the employee contribution strategy, that's, in fact,
18 exactly what I'm talking about. How does an employer
19 choose how much the employee is subsidized for its care?
20 In a very quickly dwindling number of cases, some
21 employers do, in fact, cover 100 percent of the
22 insurance. In those cases, changes in price have no
23 effect on the employee. They may well have an effect on
24 the employer, and that's why you'd need to look at
25 employer response and employee response in looking at the

1 marketplace.
2 On the other hand, there are some employers
3 that are more and more pushing the employee contribution
4 towards -- kind of asking the employees to cover more and
5 more and so, they might be faced with a 5 percent
6 increase in the cost of the HMOs or the PPOs, but the
7 employee might see a 15 or 20 percent price increase
8 because the employer has changed its strategy.
9 So, it certainly adds a complexity to the whole
10 analysis and I think that's -- in the Mercer data, there
11 was some of that and we tried to factor that in. But I
12 really don't think that we were able to get that really
13 well dealt with.
14 MR. LERNER: I'm trying to think how I could
15 add anything and I can't help myself so I'll throw out
16 two comments. One is that I think what David was
17 suggesting is that the employer, by structuring its level
18 of employer contribution towards the premium and its
19 jiggering around with what benefits it wants to have in
20 whichever multiple options it's offering, if it's
21 offering multiple options, can not only choose between
22 which plans to offer, but can also manipulate and try to
23 steer the consumers within that employer to choose one of
24 the two plans over the other, which creates a form of
25 competition within that employer.

1 The other thing I was going to mention, and I
2 think it goes back to this distinction that David isn't
3 so sure how important the distinction is and Roger says,
4 of course, how central that distinction is on this
5 question of, you know, being the market as opposed to a
6 competitor being in the market in terms of what is the
7 market versus who's a supplier that's in that market. If
8 you view a managed care provider, whatever kind of
9 license it has and imagine it as exercising market power
10 in some way other than tying up the provider community
11 with exclusive contracts or something; in other words, if
12 you view it as exercising its market power over consumers
13 and employers, but not, for purposes of discussion,
14 depriving others of access to the provider community,
15 then if they raise price and are notably seen as being a
16 monopolist or perceived as being one even if they're not,
17 the employer community, in some places, has responded by,
18 A, setting up their own HMO, years ago, setting up
19 employer coalitions that basically say, well, gee, this
20 HMO has got -- or insurance company, whoever it is, has
21 this huge mark-up, why don't we go direct to the hospital
22 community and to the provider networks and cut our own
23 contracts.
24 Some of these programs don't work very well
25 because they find out that what they thought were

1 monopoly prices maybe weren't so monopoly prices and
2 there's really not all this fat that they think they can
3 cut. But certainly the employers in those areas -- and I
4 think Paul's studies show that in those communities where
5 there's a very active, in particular, sometimes large
6 employers with a vested stake in this, do constantly
7 remind the plans that, you know, we could do without you,
8 we could go direct in one form or another.
9 Paul's studies also show that in some
10 communities where there's a lot of smaller employers,
11 maybe, or no particular leading employers or no history
12 of it, the employer community is rather passive about
13 some of these things. But I think that bears -- I think
14 it does bear on market definition, but it bears also, and
15 perhaps more centrally, on competitive effect analysis.
16 DR. FELDMAN: I just want to make sure it gets
17 read into the record that the best published study in
18 this area is by Jessica Visnis and co-authors, who found
19 that total premiums, that is the employer plus the
20 employee paid a portion, are lower in firms that offer
21 multiple choices and structure the employee's premium
22 contribution so as to make them sensitive to the price
23 differences between those choices.
24 In my study in the Twin Cities, the employer
25 that offered those two restrictive plans didn't drop the

1 merged plan because they were the only choice left for
2 them in the Twin Cities. I want to, if I could, make a
3 final point. A lot of employers offer multiple types of
4 plans, HMOs, POS plans, PPOs, a whole broad range of
5 plans. This is sometimes taken as evidence that
6 employers are willing to substitute, that they regard all
7 the plans as close substitutes. This would be an
8 incorrect inference. What it really means is that
9 employees in large firms, particularly, have very diverse
10 preferences and the employer is trying to be as good an
11 agent as they can by offering the kind of plans that
12 their employees want.
13 MR. MONK: I think that that's -- Roger's last
14 comment is correct, that employers offer multiple choices
15 because they have employees that want to choose among
16 those multiple choices. To suggest, though, that that
17 doesn't lead to inherent competition between those
18 choices seems mistaken. I'm not suggesting that Roger
19 just said that, but I have been asked -- had the question
20 posed to me, aren't they really complements as opposed to
21 substitutes. And I think what you have to do is you have
22 to analyze the data and look at the substitution.
23 What Art said is definitely true. What
24 employers have done and are doing more so today than they
25 may have been doing in 1994 is because they have multiple

1 choices, multiple options for their employees. They use,
2 what I call, the employee contribution strategy. What
3 they're asking the employees to pay, they jigger those,
4 thereby, changing the incentives of the employee. And
5 you can measure, as the employee's incentives change, do
6 they switch. And if you find that they switch, then I
7 think you've got the two products in the same market. If
8 you find they don't switch, then maybe they are
9 complements.
10 MR. BERLIN: Okay. I'll throw out what I
11 believe we'll call our last question, although we'll see
12 how many responses we get. We've heard Dr. Desmarais say
13 that there's 16 million individual purchasers of health
14 insurance in the United States versus the group market
15 and my question is, should we consider this individual
16 market or should this be treated as a separate product
17 market or, perhaps, as another dimension of the continuum
18 in determining this.
19 Art, I think I understood you to say no in your
20 presentation and --
21 MR. LERNER: No, I was only saying that one
22 wouldn't want to concede it off the bat.
23 MR. BERLIN: Okay. Well, why don't you just
24 start off and then we'll go around?
25 MR. LERNER: Actually, I don't know because

1 I've never actually thought about that a whole lot, and
2 that ought to make me not say anything right now at all.
3 I don't know.
4 DR. FELDMAN: That 16 million number seems sort
5 of high. I thought it was like 5 percent.
6 DR. DESMARAIS: The numbers are 16 million and
7 that's 16 million people under the age of 65. So, it's
8 not picking up Medigap or anything like that.
9 DR. FELDMAN: Oh, okay.
10 DR. DESMARAIS: But the number does vary
11 depending on who you look at. Sometimes it's 12 million
12 and so on.
13 MR. LERNER: You go through the merger
14 guidelines or the courts to the extent that they don't
15 use the same test.
16 DR. FELDMAN: Under some proposals for tax
17 credits, the markets would become much more similar and
18 the employer might even disappear as an agent. But the
19 way things are set up now, I'd probably argue they're
20 separate because the decision to get one or the other is
21 essentially an employment decision. Do I work for an
22 employer that offers a group policy and I would argue
23 that that decision is fairly insensitive to the price of
24 insurance since it depends on so many other things.
25 MR. LERNER: And I think it will probably make

1 the supply-side substitution issue critical, which,
2 depending on how you look at it, may not be relevant to
3 the market definition question but would be relevant to a
4 competitive effects question. If a carrier is offering
5 one or the other of these products, if they didn't offer
6 both already, could readily jump back and forth, even
7 though the consumer couldn't jump back and forth. So,
8 those questions about whether the group carrier could
9 jump into the individual market or the individual carrier
10 could jump into the group, I think would be important to
11 assessing the competitive -- to the competitive effects
12 analysis.
13 MR. DESMARAIS: What I would say is there's
14 certainly differences on the part of the consumer.
15 They're paying the full cost, so there's no employer
16 subsidy. So, that leads to very different dynamics
17 between the consumer and the seller in this case. The
18 products are also very differently regulated at the state
19 level than group coverage and that also, I think, has
20 some bearing here. Certainly -- and there's also a wide
21 range of individual types that purchase products. They
22 may be between jobs, they may be a new graduate who's no
23 longer covered by their parents' policy but haven't yet
24 acquired group coverage. They could be early retirees.
25 And each of these people, obviously, are

1 purchasing for different reasons, have different options
2 available to them about whether to get into the work
3 force and get a group coverage. So, there's a great deal
4 going on.
5 I will say that there are a number of insurers
6 who are not in the individual market because they do not
7 view it as good a business climate to be in and they are
8 in the group market. In other cases, the same insurer is
9 in all these markets. So, again, there's a lot going on.
10 MR. BERLIN: David, you get a chance to get the
11 last word on this issue and on the panel.
12 MR. MONK: So, unfortunately, I don't really
13 have much to add to it. It's not a question that I've
14 looked at, so I really don't have an opinion as to
15 whether -- what the answer would be. But I agree with
16 Art that it seems more likely that it would be driven by
17 the supply side as opposed to the demand side, which
18 means, depending upon your view of how the merger
19 guidelines should be employed, it may or may not be
20 relevant to the market definition question.
21 MR. BERLIN: Okay. We will reconvene at 2:00
22 today with a panel discussing competitive effects for
23 mergers in these markets that we've discussed this
24 morning.
25 Before we go, if we could give a hand to our

1 panelists for coming today.

2 **(Applause.)**

3 **(Whereupon, at 12:13 p.m., a luncheon recess**

4 **was taken.)**

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1 **AFTERNOON SESSION**

2 **(2:04 p.m.)**

3 MS. LEE: Good afternoon. Welcome back to the
4 Department of Justice and Federal Trade Commission's
5 Hearings on Health Care and Competition Law and Policy.
6 I'm June Lee, and David Hyman, Special Counsel at the
7 Federal Trade Commission, is co-moderating this panel.
8 This afternoon's session is Health Insurance Monopoly
9 Issues: Competitive Effects.
10 I would like to thank each of the panelists for
11 speaking and look forward to hearing their insights on
12 this topic. I will give each speaker a very brief
13 introduction and refer the audience to the handouts for
14 complete biographies.
15 After the speakers are done, we'll take a short
16 break and then Dave and I will ask questions of panelists
17 and I also invite the panelists to ask questions of each
18 other.
19 There are a couple of absences on the panel.
20 Helen Darling will be joining us late. Mike Mazzeo, on
21 the advice of his doctor, was unable to travel from
22 Evanston, Illinois. He will give us his presentation by
23 phone, though fortunately, his PowerPoint slides are
24 here.
25 We're first going to start with Lawrence Wu,

1 who will give us a general introduction to the topic of
2 competitive effects and health insurance monopoly.
3 Lawrence is Vice President at NERA. Lawrence?
4 MR. WU: Well, thank you for inviting me to
5 speak on this very important issue. Over the past three
6 decades, the health insurance industry has seen dramatic
7 changes both in terms of the products that have been
8 offered and the nature of competition in the marketplace.
9 And we've come a long way from the time that economists
10 were concerned that competitive health insurance markets
11 may not even be possible due to factors such as adverse
12 selection and imperfect information. Today, I think
13 there's little doubt that competitive health insurance
14 markets are not only possible, but also likely.
15 My comments today will focus on three
16 questions. First, what is harm to competition? Before
17 we start talking about competitive effects, we ought to
18 define it.
19 Second, when evaluating allegations about the
20 exercise of market power, what kinds of dynamics should
21 we consider? Put differently, what are the conditions
22 that keep health insurance markets competitive? I think
23 this is important because part of an evaluation of
24 competitive effects of a merger or business practice is
25 an articulation of how that merger or business practice

1 changes competitive conditions.
2 And, third, what are the measures and methods
3 that can help us evaluate harm to competition and are
4 they useful in identifying changes and competitive
5 conditions?
6 So, let's begin with an overview of what
7 constitutes harm to competition. Competition has been
8 harmed when the process of competition has been distorted
9 in a way that leads to prices rising above competitive
10 levels or quality falling below competitive levels for a
11 sustained period of time. Thus, to evaluate whether a
12 merger is likely to harm competition one would determine,
13 for example, in a merger matter whether the merger would
14 enable the merging parties to raise price above
15 competitive levels for a substantial period of time.
16 An important part of this analysis is to
17 consider whether the forces that are driving competition
18 prior to the merger will remain, and therefore, continue
19 to drive competition after the acquisition. If
20 competitive conditions are not likely to change, then it
21 is not likely that the proposed transaction would harm
22 competition. On the other hand, if the acquisition
23 changes competitive conditions so that prices are likely
24 to rise and stay at supra-competitive levels, then
25 competition would be harmed.

1 So, in the U.S., health insurance markets are
2 generally viewed as being competitive, at least that's
3 the consensus among the health economics textbooks that I
4 glance through, and I think that's a good starting point
5 for a competitive analysis because if we can identify
6 whether and how a merger or business practice has changed
7 or is likely to change competitive conditions, then we
8 can begin to articulate a theory of competitive harm.
9 So, let's start at the beginning with an
10 overview of the conditions that I believe generally make
11 health insurance markets competitive and these are the
12 seven -- there are seven I'll discuss today and we'll go
13 through those seven. Again, I want to think about those
14 seven because I think they will help us evaluate the
15 indicia we typically look at when evaluating competitive
16 effects and exercise of market power.
17 So, number one, health insurance can be
18 provided in a number of different ways. Now, one reason
19 why health insurance is so competitive is simply the
20 nature of the business. Health insurance carriers are
21 primarily in the business of putting together all of the
22 different functions and services of a health insurer,
23 such as underwriting the risk, developing a provider
24 network, utilization management and the provision of
25 claims processing and other administrative services.

1 Now, each of these elements can be put together
2 by insurers on the supply side or by employers on the
3 demand side in any combination they choose. And what
4 this means is that many of the services provided by an
5 insurer can be unbundled and combined again. So, for
6 example, on the one hand, there are HMOs and PPOs that
7 perform all of these functions in-house, and at the other
8 extreme, there are health plans who outsource all of
9 these functions.
10 So, for example, there are employers who choose
11 to be self-insured, thereby bearing the financial risk,
12 but contract with a third-party administrator for claims
13 processing and other administrative services. Of course,
14 there are all the permutations that fall in between these
15 two ends. For example, many health plans choose to
16 perform the claims and benefits processing and they do
17 the utilization review, but they also contract with a
18 third party to obtain access to a network of providers.
19 And, in fact, there are companies that
20 specialize in each of the functions that comprise health
21 insurance coverage. There are scores of third-party
22 administrators who specialize in claims processing and
23 benefits administration and a fairly large number of
24 companies whose primary business is to create a network
25 of providers that they then sell or rent to other

1 insurers or employers.

2 I think if we think about health insurance as
3 the business of putting together the various contracts
4 and functions that are needed to pay for health care
5 services, then I think it's a little clearer why many
6 view the industry as being fundamentally competitive.

7 Number two, the ease of expansion. The
8 business of health benefits coverage is primarily about
9 the contractual relationships that a carrier has with its
10 health care providers and with its customers. And
11 because of this, capacity constraints don't have much
12 meaning for health plans and that is because, with
13 respect to provider contracts, carriers are generally
14 free to enter into contracts with providers which means
15 that the only limit on the number of contracts that a
16 carrier can enter into is the number of providers that
17 are available to serve that market.

18 Likewise, for an existing health plan, the
19 incremental cost of expanding capacity is relatively
20 small and there is no limit to the number of customer
21 contracts that a carrier can enter into. And, again, the
22 regulatory hurdles here are minor in most cases, so, for
23 example, once an HMO has a license to operate in one part
24 of the state, it's relatively easy for that HMO to get
25 the license to expand into other parts of the state.

1 That's number two.
2 Number three, in health insurance markets,
3 buyers generally are informed and sophisticated customers
4 and this is -- there's one important reason why the
5 insurance market is competitive and that is because most
6 of the shopping is done by employers. Now, employers are
7 informed and sophisticated because they also rely on a
8 whole other industry to help them stay informed, that
9 industry being comprised of brokers, agents and
10 consultants. They help employers devise a solution that
11 best fits the company's needs. They give companies
12 advice on designing a health benefits plan, and in so
13 doing, they can facilitate the entry and expansion of
14 insurers, large and small.
15 Consultants here play an especially important
16 role in the facilitating substitution from one insurer to
17 another. So, for example, consultants can help employers
18 develop a request for a proposal which is then sent to
19 competing health plans, and because consultants also help
20 employers design the proposal and select the winners,
21 they facilitate the process by which substitution can
22 occur among the various insurance solutions in the
23 marketplace, and that substitution is at the heart of
24 competition.
25 In health insurance markets, competition takes

1 place in bidding contests. When employers make decisions
2 about the health benefits plans that they offer their
3 employees, they typically put it out to bid. For large
4 firms, it's typically a more formal process where the
5 consultants might actually survey the firm's employees
6 about their preferences and then follow up with a design
7 for a health benefits plan. It's not just the large
8 firms that can benefit from that, but small to mid-size
9 firms as well who rely on brokers to do the same thing.
10 Brokers might also design and develop a request
11 for proposal, and it could take place on a formal basis,
12 but again, it could also take place on a less formal
13 basis. But, again, they might go to individual carriers,
14 get the rate and benefit quotes and bring it back to the
15 employer.
16 Again, once we recognize that competition takes
17 place through bids and RFPs, the role of brokers and
18 consultants in facilitating substitution and in
19 facilitating the entry and expansion of a smaller carrier
20 becomes clearer.
21 The next condition, the willingness of
22 individual consumers to switch health plans based on
23 price. Even after a health plan is selected to be among
24 the plans offered to employees, the competition has just
25 begun, and that's because the empirical evidence suggests

1 that consumers are highly sensitive to price. So, for
2 example, one recent study found that consumers are very
3 sensitive to out-of-pocket premiums and are willing to
4 switch health plans in response to small changes in
5 relative premiums.
6 In fact, one recent study, for example, found
7 that individuals facing an increase in premiums from zero
8 to $10 were five times more likely to switch plans
9 compared to those whose premiums did not change. If
10 consumers are this sensitive to price, this puts a great
11 deal of pressure on health plans to price their products
12 at competitive levels. And moreover, the high degree of
13 consumer price sensitivity is also likely to lead to a
14 great deal of churn; that is, switching from one health
15 plan to another. And, in fact, the percentage of health
16 plan subscribers who change plans in any given year could
17 be as high as 20, 25 percent. That's a lot of movement.
18 Employers also have bargaining leverage.
19 Employers have some buyer power because most people get
20 their health benefits through their employer. In other
21 words, competition tends to be fierce when there are
22 large amounts of business at stake. So, for example,
23 it's the employer who decides whether to offer one plan
24 to their employees or ten, and it's the employer who
25 generally shares the costs of health care with their

1 employers, and with the help of their consultants,
2 determines the premiums to be paid by its employees for
3 each plan. In other words, the employer has tremendous
4 bargaining power because it can essentially dictate the
5 nature and terms of competition among the health plans,
6 not just only competition to be among the plans offered
7 to employees, but dictate the terms of competition that
8 drives consumer choice.
9 And the last condition I want to talk about is
10 entry as an effective source of competition. Now, this
11 is the subject for a hearing that will be held tomorrow.
12 So, let me just show you one picture, one picture that
13 basically tells 1,000 words.
14 In 1994 in the Atlantic City, New Jersey, area,
15 the leading health plan was Blue Cross/Blue Shield of New
16 Jersey, which had a 38 percent share of HMO/POS
17 enrollment in that metropolitan area. In just four
18 years, there were eight new entrants. As you can see,
19 they did well. In 1998, the entrants, which is the party
20 of the pie that's blue, collectively had a 47 percent
21 share of HMO/POS enrollment in the area. These are plans
22 that did not exist in 1994 in Atlantic City/Cape May.
23 What happened to the share of the largest plan
24 in 1994? That's the pink slice of the pie which belongs
25 to BCBS of New Jersey, and that share shrunk by 17

1 percentage points. Among the new entrants is
2 AmeriHealth, which in three years time became the leading
3 HMO in the city with a 30 percent share. This is the
4 tale of one city, but in an analysis that my colleagues
5 and I did on four years of interstudy HMO data across 46
6 cities, we found that entry and expansion was
7 systematically effective in taking share away from the
8 largest firm in the service area.
9 Now, this shouldn't be surprising because
10 consumers are generally willing to switch health plans,
11 and in a bidding environment where a new carrier can get
12 a lot of business right away, even with one competitive
13 bid, this is especially important. This way, a small
14 insurer can double or triple its revenues and enrollment
15 with one account.
16 Now, I want to describe the seven stylized
17 facts and market conditions because I think they reveal
18 the variety of competitive pressures that face health
19 plans in the marketplace. If we understand these
20 competitive pressures, then we'll be in a better position
21 to evaluate the indicia that are often cited or relied
22 upon to evaluate the competitive effects of a merger or
23 business practice. After all, for a merger or business
24 practice to result in higher prices or less product
25 competition, there must have been some change in

1 competitive conditions.
2 There are a number of indicia that are commonly
3 used to evaluate harm to competition and health insurance
4 markets, but three stand out and they will be the ones I
5 talk about today. One is market shares and share-based
6 market concentration statistics, like the HHI. Second,
7 medical loss ratios or profits margins. And, third,
8 elasticities of demand which measure the degree of
9 consumer price sensitivity.
10 Let me start with the usefulness of the market
11 share information because market share data are so
12 commonly cited and relied upon. But I think we really
13 need to be cautious when we think about market shares
14 because they really tell us very little about a health
15 plan's market power and I want to tell you why I think
16 that's the case.
17 First and foremost, an analysis of market
18 shares is typically a restatement about one's conclusions
19 about market definition. So, a person who believes that
20 the relevant market is comprised of HMO enrollment in a
21 particular city is likely to calculate shares on that
22 basis. And someone who believes that the market includes
23 all health insurance sold across the state is likely to
24 calculate market shares that way.
25 But let's put that aside for a moment because

1 what I want to point out is that even if there were no
2 dispute about market definition, there are still many
3 reasons why a snapshot of market share data would not
4 provide us with much information about the degree of
5 competition in that market.
6 First, market share is not a useful indicator
7 of a firm's ability to compete when expansion or entry is
8 accomplished easily, and that is because market share is
9 a measure of a firm's historical success rather than the
10 ease with which it can expand in response to an attempt
11 to exercise market power. And this is especially true
12 for a smaller insurer whose enrollment could easily
13 double or triple if it wins one or two accounts. And in
14 this way, an insurer's enrollment could change
15 dramatically from year to year. So, in other words,
16 market share can under-state a smaller firm's ability to
17 compete just as easily as it can over-state a larger
18 firm's ability to compete.
19 Second, in a bidding environment, aggregate
20 market shares tend to be a poor indicator of competitive
21 viability. With one competitive bid, a health plan can
22 get a lot of business right away. Thus, a carrier's
23 market share, if it is based on past enrollment, is a
24 poor indicator of that firm's capacity to compete in the
25 future.

1 Next, it's hard to interpret high market shares
2 even when they are stable or when a health plan
3 consistently has a high market share. Now, why is that?
4 One issue is that data on market-wide enrollment and
5 shares hide a lot of competitive activity and churn, and
6 with consumers so sensitive to price, this is not
7 surprising, but something very important, something we
8 need to continue to be aware of when we evaluate market
9 share statistics.
10 There's a lot of enrollment and disenrollment,
11 so even though aggregate shares may appear stable, there
12 is still a lot of switching by individual consumers.
13 Fourth, market share is also an indicator of
14 relative efficiency or quality; that is, firms with high
15 market share may be the more efficient, higher quality
16 and innovative health plans in the market who are being
17 basically rewarded for the services they provide.
18 Fifth, enrollment and shares often do not
19 account for all the ways that health insurance can be
20 arranged. Data on HMO and PPO enrollment, for example,
21 do not account for the ability of employers to develop
22 self-insurance plans or the ability of another health
23 plan to reposition itself.
24 Six, there are frequently issues related to the
25 data that are available and this is very similar to the

1 previous point. Data are generally available for HMOs,
2 but data on PPO enrollment is much poorer. Part of the
3 reason is that PPOs are less regulated than HMOs and thus
4 lack many of the reporting and operating standards that
5 HMOs have. So, it's hard to get accurate data on PPO
6 enrollment. It's even harder to get data on indemnity
7 plans. But these are all important health care insurance
8 solutions.
9 Now, I don't want to sound too dismal, so let
10 me offer some suggestions on the indicia that might be
11 helpful in evaluating competitive effects.
12 If we are to focus on enrollment and shares, I
13 think it's useful to study shifts in market shares over
14 time and I think this would be a great way to test
15 whether entry and expansion, in fact, is easy. The
16 problem, as I mentioned earlier, is that with a static
17 analysis, it's possible that the market might be served
18 by a handful of large firms and many, many small firms,
19 and although one might want to conclude that small firms
20 stay small and big firms stay big, this is typically not
21 the case and definitely not a safe assumption in an
22 industry where we have seen big health plans fail and
23 many small firms rising to the top.
24 Looking at profit margins or medical loss
25 ratios are also frequently done. In the case of health

1 insurance, one commonly computed statistic is a medical
2 loss ratio which is the ratio of medical expenses to
3 premiums. If a health plan has high and persistently low
4 medical loss ratios, which may correspond to higher
5 profits, that could be one indicator consistent with the
6 proposition that the plant has market power.
7 But even here, we're not all the way home
8 because there are still issues of measurement and
9 interpretation. For example, medical loss ratios tend to
10 vary widely by product and the medical loss ratio may
11 fall if the health plan is doing many of the things
12 employers really want health plans to do, like take on
13 responsibilities to assure quality, profile providers,
14 review utilization, and these are all functions that
15 reduce medical cost, yet require administrative
16 resources. And so, these are responsibilities that might
17 lead to lower medical costs and lower medical loss
18 ratios.
19 And the last one I'll mention, the last
20 statistic I'll mention is the elasticity of demand, which
21 is a concept that has found its way into many studies of
22 market competitiveness in health insurance markets and a
23 high elasticity of demand, which is typically the
24 finding, would suggest that consumers are willing to
25 switch health plans in response to changes in price and

1 this would be a finding consistent with competition.
2 Such an analysis is likely to involve an econometric
3 study and there are numerous approaches that can be
4 taken.
5 So, in the end, conclusions regarding the
6 competitive effects of a proposed merger or business
7 practice are likely to rest on a number of facts. For
8 example, evidence of harm to competition could include a
9 demonstration of high and sustained prices and/or high
10 and sustained profit margins. And to corroborate the
11 analysis, a study of the relevant elasticities of demand
12 might also be helpful.
13 Also, an analysis of competitive harm should
14 include a clear articulation of the ways in which a
15 merger or business practice would result in higher prices
16 for a sustained period of time. And to do this, what we
17 really need is an explanation of how competitive
18 conditions have changed or are likely to change as a
19 result of a merger or business practice.
20 I have an open mind, but, in general, health
21 insurance markets do have many of the features that help
22 to ensure competition. And to paraphrase the title of a
23 song written by Paul Simon, that is because there are
24 probably more than 50 ways to leave your health plan.
25 So, I'm going to use that to summarize the competitive

1 dynamics that I think form the start of an analysis of
2 competitive effects. Now, again, I focus on the
3 competitive conditions because what we want to focus on
4 is how a merger or a business practice changes those
5 conditions.
6 Just slip out the back, Jack, and turn to
7 another health plan, which is made easier by the
8 willingness of individual consumers to switch plans.
9 Make a new plan, Stan, because with the help of
10 brokers and consultants, health insurance can be arranged
11 a number of different ways.
12 You don't need to be coy, Roy, because
13 employers are informed and sophisticated.
14 Just get yourself free.
15 Hop on the bus, Gus, because health plans can
16 expand easily across geographic and product space.
17 You don't need to discuss much because
18 competition takes place in a bidding environment.
19 Just drop off the key, Lee, because the key is
20 effective entry.
21 And get yourself free.
22 Thank you for the opportunity to speak today.
23 I appreciate that.
24 **(Applause.)**
25 MS. LEE: Our next speaker is Mike Mazzeo,

1 who's a Professor of Management and Strategy at the
2 Kellogg School of Management at Northwestern University.
3 He is joining us by phone, so I'm going to adjust the
4 microphone. Let me know if there are any problems
5 listening to him. We do have his Power Point slides, so
6 Julia, can I ask you to move those along as he's going.
7 DR. MAZZEO: Good afternoon and thank you for
8 giving me the opportunity to present to you today and, in
9 particular, for the opportunity to present remotely.
10 I want to talk today about some recent research
11 that I have done regarding the question, how does product
12 differentiation affect competition in HMO markets.
13 What I will discuss this afternoon are the
14 highlights of a paper that I have co-written along with
15 my colleagues at Kellogg, David Dranove and Ann Gron.
16 The title of the paper is Differentiation and Competition
17 in the HMO Markets, and it will be published later this
18 year in the Journal of Industrial Economics.
19 I've left most of the technical material out of
20 this presentation, but have submitted a copy of the
21 paper, along with my testimony, in case people are
22 interested in those details.
23 As I mentioned, this paper examines the
24 connection between product differentiation and
25 competition in HMO markets. As in many markets, product

1 differentiation has the potential to reduce competition
2 among HMOs, particularly if consumers -- and here I mean
3 employers -- of HMOs don't find the products offered by
4 differentiated firms to be perfect substitutes.
5 Unfortunately, as was previously described, given the
6 nature of the HMO industry, some of the standard
7 techniques used to evaluate competition and
8 differentiation are not feasible.
9 Lawrence talked about calculating demand
10 elasticities. It's problematic for HMOs since prices are
11 determined often by individual negotiations between HMOs
12 and employers and because the specific services included
13 can be different on a contract-by-contract basis.
14 However, more simple competition metrics, such as
15 concentration ratios, can be misleading to the extent
16 that they don't explicitly account for the effects of
17 product differentiation.
18 Therefore, we have utilized a different
19 framework for measuring the effects of additional
20 competition on HMO profits, one that specifically
21 distinguishes between the impact of competitors based on
22 whether they offer differentiated services or whether
23 they offer similar services to the other HMOs in their
24 market.
25 As I will discuss more below, we compared two

1 types of HMOs in this study, ones that operate only
2 locally and ones that have a regional or a national
3 network available throughout the United States. The
4 results that we found, using geographic scope as the
5 basis for classifying differentiation, were striking.
6 However, other forms of differentiation could be examined
7 using this framework as well.
8 We estimated our model using data from a cross-
9 section of small MSAs and other large rural counties in
10 the U.S. These markets varied considerably in their
11 demographic characteristics and in the market structure
12 of the HMOs in the area. The HMO data that we used for
13 this study came from the interstudy data set for the year
14 1998.
15 Just a note on the geographic scope product
16 differentiation of HMOs before we get started. The
17 histogram in this slide indicates that most of the
18 operating HMOs that we identified operated locally. So,
19 there were a total of 137 HMOs in our data set and 112 of
20 them operated in areas that represented less than 5
21 percent of the U.S. population. In contrast to those,
22 there are a handful of HMO firms that operate over a very
23 wide geographic area, some approaching a national
24 network.
25 National HMOs may be more attractive to certain

1 employers, ones that have multiple establishments spread
2 across the country, as they can offer one health plan to
3 all of their workers by contracting with this national
4 HMO, provided that they're available in each local area.
5 Other employers may value local HMOs more
6 highly, particularly if these HMOs have ties to
7 particularly local service providers that are prominent
8 in the community.
9 So, our empirical framework is based on the
10 concept of entry threshold ratios, which were introduced
11 into economics by Bresnahan and Reiss in the early 1990s
12 and which have helped guide policymakers since.
13 This methodology is based on the following
14 basic insights. Firms will enter markets only if the
15 costs of doing so are less than the profits that can be
16 earned once the firms have entered. These post-entry
17 profits can be divided into the profit margin earned by
18 operating firms and the quantity that they sell. How
19 does competition enter this framework? Well, if it turns
20 out that markets with more operating firms are also more
21 competitive, which results in lower profit margins, then
22 the quantity that firms need to sell post-entry must be
23 larger to make up for the lower margins and to still
24 offset the entry costs. A priori, we don't know the
25 extent to which additional competition reduces margins,

1 but we can infer this by comparing market size per firm,
2 a measure of quantity, across markets of different sizes.
3 So, let me explain a little bit more about
4 that. Such a comparison is done by calculating entry
5 threshold ratios in a cross-section of markets in a
6 particular industry. So, markets are grouped based on
7 the number of firms that are operating, then the average
8 market size, composed mainly of population, but also
9 weighted by other demographic characteristics, the
10 average market size for markets in each group is then
11 calculated. So, the entry threshold ratio that coincides
12 with the Nth competitor in a market is the ratio of the
13 average market size per firm in markets with N firms over
14 the average market size per firm in markets with N minus
15 one firms.
16 If this ratio is greater than one, then we can
17 infer the following: The entry of the Nth firm reduces
18 margins for operating firms in the industry. The logic
19 is straightforward. A larger market size per firm is
20 associated with markets that have that one additional Nth
21 competitor. The fact that this extra quantity is needed
22 suggests that competition is more intense once you have
23 that extra firm in the market.
24 However, if the entry threshold ratio equals
25 one, indicating the same market size per firm in markets

1 with N firms and markets with N minus one firms, then we
2 infer that the presence of the Nth firm does not reduce
3 industry margins. The quantity needed to support one
4 additional entrant has remained the same.
5 So, Bresnahan and Reiss calculated their entry
6 threshold ratios for a number of relatively homogenous
7 service industries and I've graphed the pattern here on
8 this slide and the pattern that they found, looking at
9 these homogeneous industries, was very consistent. The
10 entry threshold ratio for the second firm entering these
11 markets was significantly greater than one, indicating
12 that moving from monopoly to duopoly reduced margins
13 substantially.
14 As the number of firms in the markets
15 increased, the entry threshold ratios in these industries
16 converged toward one. This was interpreted to indicate
17 that a competitive market was achieved once these
18 industries had four or five operating firms since the
19 presence of extra competitors beyond that did not reduce
20 margins any further. Now, such a result can provide
21 guidance for policymakers regarding what sorts of mergers
22 to be more or less concerned about and which ones may not
23 be likely to have a competitive effect.
24 So, using our data on HMOs, we set out to
25 calculate entry threshold ratios for this industry. Now,

1 as you can see from the raw data, we had a total of 263
2 markets included in our data set and most of these
3 markets had between two and eight operating firms.
4 Once we matched these markets with their market
5 sizes and calculated the entry threshold ratios for HMOs,
6 we found a very striking pattern. Now, it's useful to
7 compare the HMO findings by super-imposing the ratios on
8 the same graph as was shown on the earlier slide. So,
9 here, in contrast, we see that the second operating HMO
10 has an entry threshold ratio that's very close to one.
11 Now, remember, this indicates that the second HMO in the
12 market does not cause profit margins to fall. Only when
13 a third HMO enters do we see the entry threshold ratio
14 rise to above one, and there, it is comparable to the
15 second firm in the other industries that are listed on
16 the graph.
17 After three firms, the entry threshold ratios
18 for HMOs follow the same pattern, reducing toward one,
19 albeit a little more gradual than the other industries.
20 So, it appears from these data that there's a
21 fundamental difference between HMOs and the other
22 industries studied using this technique, and the presence
23 of competition reducing product differentiation can help
24 explain these striking results. If there are, for
25 example, two distinct types of HMOs that don't compete

1 with each other directly, then a particular market might
2 not become more competitive with the entry of a second
3 HMO. Now, provided that, of course, it's the second HMO
4 that enters is differentiated from the first HMO that was
5 already in operation.

6 The third HMO that enters would then compete
7 more or less directly with at least one of the other two
8 firms, necessitating additional quantity in order to make
9 entry profitable and that's why you see the entry
10 threshold ratio rising with the third firm.

11 Since the pattern above is consistent with
12 product differentiation reducing competition among HMOs,
13 we spend the rest of our analysis examining this issue
14 directly.

15 Now, I won't go into the details of the
16 empirical model that we estimate but to mention two
17 important aspects of the model. First is that now we're
18 comparing a more nuanced notion of market structure in
19 our data set. So, instead of grouping markets by the
20 total number of operating HMOs, we can define what we
21 call a product type configuration for each market and the
22 product type configuration is an ordered pair with the
23 first number indicating the number of national HMOs that
24 are operating and the second number indicating the number
25 of local HMOs. As we'll see in the next slide, markets

1 are grouped for this analysis based on the values of the
2 ordered pair. Second, we estimate an underlying economic
3 relationship for profits of HMOs using the cross-
4 sectional data.
5 Parameters in the model incorporate two types
6 of effects. Market effects, such as population and other
7 demographic characteristics, are allowed to have a
8 varying effect on the profitability of local HMOs and
9 national HMOs, and the competitive effects reflected on
10 the profits are reduced by the entry of another competing
11 HMO. Importantly, these competitive effects are computed
12 separately for same type and for different type firms.
13 So, a key comparison that we can make is the following:
14 How does the presence of one local HMO competitor affect
15 the profits of a local HMO and how does that compare to
16 the effect that the presence of one national HMO
17 competitor has on the profits of a local HMO?
18 Now, here is the slide with the list of the
19 product type configurations in the data set that we've
20 put together here. The histogram presents the raw data
21 across our markets and the ordered pair of operating
22 firms for each type are on the axis and the number in the
23 table reflects the number of markets that have the
24 corresponding prior type configuration as their market
25 structure.

1 So, for example, there are seven markets with
2 the 0/1 product type configuration, that is zero national
3 firms operating and one local HMO in the market. Before
4 reviewing the empirical results, it is useful to note the
5 striking pattern of product differentiation in HMO
6 markets that is reflected in the numbers in this table.
7 This is evidenced by the relatively large numbers on the
8 diagonal of the table as opposed to the edges.
9 For example, let's look at markets with exactly
10 two HMOs operating. We see that 24 out of the 31 such
11 markets in the data set have the 1/1 product type
12 configuration. This pattern continues as the number of
13 operating HMOs increases. This provides further evidence
14 that product heterogeneity is important in HMO markets as
15 evidenced by the patterns of entry that have emerged
16 across the markets in the U.S.
17 If there is one operating HMO and that HMO is
18 part of a national network, then the next entrant into
19 that market is very likely to be a local HMO and vice
20 versa. So, along with the evidence from the entry
21 threshold ratios, this appears to indicate a strong
22 relationship between product differentiation and
23 competition reduction in HMO markets.
24 Now, I only want to briefly mention the
25 estimated parameters in the model. The key results,

1 again, are outlined in more detail in the paper. On the
2 competitive effects, the important finding is that the
3 effect of same type competitors is much larger than the
4 effect of competitors of the other type, which are
5 negligible. This is true for both the local HMOs and the
6 national HMOs in the markets that we studied. Such
7 results are clearly in line with the differentiation
8 pattern in the raw data, which were seen on the previous
9 slide.
10 Now, in addition, we have the market effects
11 and the interesting fact to note here is that some of the
12 demographic characteristics of markets affect the
13 profitability of local and national HMOs differently,
14 thus attracting each of these to their markets in greater
15 proportion.
16 I highlight one difference here, the share of a
17 market's residents that are age 65 and above. In markets
18 with more older residents, national HMOs were found to be
19 more prominent than local HMOs, which may reflect
20 advantages that national HMOs have in serving elderly
21 patients more efficiently. Either way, the difference in
22 these estimated parameters suggests that the connection
23 between market structure and competition would be
24 potentially different depending on the particular
25 characteristics of the markets in question.

1 So, to conclude, while this paper is
2 predominantly an exercise in positive economics with
3 strong findings that connect product differentiation and
4 competition reduction in HMO markets, I think that there
5 are some potential bits to take toward policy evaluation
6 from the results presented here.
7 Given the difference in competitive effects
8 within and across product types, a clear understanding of
9 the characteristics of HMOs that were planning to merge
10 would be necessary to accurately forecast a merger's
11 competitive effect. So, for example, suppose that two
12 firms in a 2/3 market were planning to merge. The
13 results here suggest vastly different impacts on
14 competition if two locals were to merge, making the
15 resultant market structure a 2/2 product type
16 configuration versus if two national HMOs were to merge,
17 leaving the market to have a 1/3 product type
18 configuration.
19 Likewise, some takeovers could be pro-
20 competitive depending on the initial market structure.
21 If a national were to enter a 3/1 market by taking over
22 one of the local HMOs, a more competitive 2/2 product
23 type configuration would result. Finally, it is worth
24 recalling that demographic characteristics affect
25 national and local HMOs differently. Therefore, any

1 competitive effects analysis would need to look at
2 detailed impacts on a market-by-market basis to correctly
3 assess the results.
4 Thank you very much.
5 MS. LEE: Thank you, Mike.
6 **(Applause.)**
7 MS. LEE: Next, Steven Pizer is at the Center
8 for Health Quality Outcomes and Economic Research, the
9 Department of Veterans Affairs and the Boston University
10 School of Public Health. Steve?
11 MR. PIZER: I'm Steve Pizer, as June just said,
12 and the Center for Health Quality Outcomes and Economic
13 Research where I work is that nice place in beautiful
14 Bedford, Massachusetts. I like to give them a little
15 plug.
16 Today, I'm going to be talking about
17 competition in the Medicare Plus Choice program. In
18 light of some of the comments, made particularly by
19 Lawrence earlier, but also by Mike, Medicare Plus Choice
20 is particularly interesting. It's a relatively small
21 part of the overall health insurance market, but it's
22 interesting because it may be more vulnerable to problems
23 in competition than some other broader market.
24 I should acknowledge the Centers for Medicare
25 and Medicaid Services for financial support for the

1 research that I'm going to be talking about and also
2 acknowledge my colleagues, Austin Frakt and Robert
3 Coulam, with whom I worked on some of this research.
4 When we were contacted about testifying or
5 presenting today, we were given a number of questions to
6 think about. So, in a different order I've reproduced
7 them here. The one that really struck me the strongest
8 was when should the agencies be concerned about
9 coordinated effects arising from a merger. So, that's
10 the question that I kind of have in the back of my mind
11 when I'm talking. And there are some answers to that
12 question that were suggested by some of the other
13 discussion points. One is, when products are close
14 substitutes. So, if two firms are merging and the
15 products that they supply are substitutes for each other
16 or there's lack of product differentiation, there might
17 be a reason for concern.
18 When demand for the products is inelastic, and
19 that could be because of brand loyalty was one of the
20 reasons that was suggested, but there are other reasons
21 that I'll suggest later. And one that wasn't suggested
22 in the discussion points is, when industry concentration
23 already has demonstrable effects on price and on quality.
24 And I'll -- the results that I'll present today will
25 really focus on that area.

1 Why focus on Medicare? There's less group
2 purchasing and self-insurance in the Medicare market than
3 there is in the broader market for the working
4 population. It tends to make markets more local, I would
5 argue. Product differentiation is constrained by
6 regulation of the products, so there's more homogeneity
7 of products. And demand for insurance, at least in our
8 experience, seems to become less elastic with age; in
9 particular, as Medicare beneficiaries get into their late
10 70s and 80s, they're much less likely to switch plans.
11 Finally, Medicare reform proposals that have
12 been floated recently in Congress and by the
13 Administration rely very heavily on healthy competition
14 between plans as a vehicle for providing efficient
15 benefits to beneficiaries; in particular, prescription
16 drug benefits. So, this could become much more important
17 in the near future.
18 Let me give you a little bit of background
19 about what Medicare Plus Choice is. It's a part of
20 Medicare. It provides coverage to about five million
21 Medicare beneficiaries right now through private HMOs,
22 primarily. That's about 15 percent of the Medicare
23 population.
24 Plans are paid by the government according to
25 administratively determined rates and they may also

1 charge a premium. Plans may offer benefits above the
2 standard Medicare package. The most attractive of these
3 benefits is prescription drug benefits, outpatient
4 prescription drug benefits and there's quite a variety of
5 the generosity of those benefits that are offered.
6 Just a little bit of background about
7 competition in Medicare Plus Choice. There's been a lot
8 of concern about it. There have been attempts to
9 introduce competitive pricing as a means of setting
10 payment rates in Medicare Plus Choice. For a number of
11 years, those attempts have not been successful. So,
12 payment rates continue to be established through an
13 administrative mechanism with Congressional input.
14 Since historically many of these plans have
15 charged zero premiums, competition often is limited to
16 competition on benefits. This is a little less true in
17 recent years as premiums have become more common. As
18 I'll show you shortly, the Herfindahl Index and the
19 actions of other plans do affect premiums and they also
20 affect benefit decisions.
21 And, finally, there's a new type of plan that
22 just came into being in the last couple of years. It's
23 called a private fee-for-service plan. It's different
24 from traditional HMOs, much more like a fee-for-service
25 indemnity plan and there's two plans right now I'll be

1 talking about. One of them that has recently entered a
2 number of markets where HMOs exited and it might
3 represent an important source of new competition, but
4 it's still very small right now.
5 So, I'm going to be talking about two studies.
6 The first was engendered by the passage of a new payment
7 law in late 2000, which created a natural experiment and
8 this was valuable for us as researchers because it gave
9 us the opportunity to separate the effects of payment
10 rates and of competition variables like industry
11 concentration from the effects of unobservable costs, and
12 then we could compare the effects of payment rates to the
13 effects of competition to get a sense of how important
14 our competition variables were. That's the first study.
15 The second study focuses on the private fee-
16 for-service plan that began enrolling beneficiaries in
17 June of 2000. And this gave us the opportunity to study
18 market entry and to learn a little bit about how the same
19 competitive variables that we were looking in the first
20 study affected the probability of market entry.
21 So, just talking about the first one, Congress
22 passed the Benefits Improvement and Protection Act -- the
23 acronym is BIPA -- in late 2000 and what that did, among
24 many other things, was to mostly increase payment rates
25 that had gone into effect in January or were set to go

1 into effect in January of 2001. So, ordinarily in
2 Medicare Plus Choice, there's sort of an annual ritual
3 dance where data is collected, payment rates are
4 established, plans made decisions in response to that in
5 terms of what benefits they're going to offer and what
6 premiums they're going to offer and what markets they're
7 going to play in. And then in January, all these plans
8 take effect and the process starts again for another
9 year.

10 Since the underlying costs change over the
11 course of the year, it's a little hard to separate the
12 effects of the changes in underlying costs, say changes
13 in prescription drug costs, from the changes in the
14 payment rates. But in the wake of BIPA, a set of payment
15 rates and a set of benefits and premiums and market entry
16 decisions went into effect January of 2001. Then the
17 effect of BIPA hit and everything changed as of March of
18 2001. So, we had an opportunity to isolate attention on
19 the effect of the payment rates without having much
20 underlying change in cost.

21 I'll run very quickly through the data. We had
22 data for January and March of 2001, which is the key time
23 period, and we merged data from a number of different
24 sources, which I won't really go into.

25 The sample, we had about 1,100 planned counties

1 for both January and for March. We had to drop some
2 because of missing data, but we ended up with about 4
3 million out of the 5.6 million Medicare Plus Choice
4 enrollees as of that time, so about 71 percent of the
5 Medicare Plus Choice population.
6 This is the empirical specification. I won't
7 spend a lot of time, I guess. But we had equations for
8 premiums, that's the top equation, and premiums for
9 benefits. There were two equations for premiums. One is
10 for whether the plan charged a premium at all, so that's
11 a binary choice, did they charge a premium or did they
12 not, and then another equation for what was the level of
13 the premium if they did charge one. And then we had a
14 number of benefits equations, as well, for things like
15 co-payment levels for prescription drugs, brand name
16 drugs, generic drugs, co-payment levels for visits to the
17 doctor, whether or not the plans offered dental benefits
18 and whether or not the plans offered drug benefits.
19 You'll recognize the word "March" which stands
20 for the month of March. Supply and demand are vectors of
21 a bunch of other variables. I'll mention those in a
22 minute. The Herfindahl Index, you will recognize. The
23 variables, other premium and other benefit, those are
24 variables that were constructed to reflect what other
25 plans in the county were doing. So, if the equation is

1 for whether or not the plan charged a premium, that other
2 premium variable would reflect whether any other plans in
3 the county charged a premium. If the equation was for
4 what the premium level was, then that other premium
5 variable would be what the average premium level was for
6 other plans in the county.
7 Actually, let me emphasize that on both the
8 Herfindahl variable and the other premium or other
9 benefit variables, those variables are lagged by one time
10 period. This is a bit of a technical concern, but one
11 that gets at something that Lawrence mentioned earlier.
12 We want to make sure that we get the causation right and
13 there's a little bit of concern about endogeneity about
14 these variables, so we lag them one period to address
15 that.
16 This is just the list of the supply variables
17 and the demand variables. Things that you might expect
18 like historical Part A spending for an idea of what the
19 geographic -- the historical geographic costs are in the
20 area, the number of physicians per capita, urban/rural
21 status, hospital beds per capita, some risk score data
22 that we got from CMS, per capita income, proportion of
23 population over the age of 65. We also included plan
24 level fixed effects in this specification because the
25 unit of observation is the planned county and we

1 recognize that a lot of plans don't naturally make all
2 their decisions at the county level. There's a certain
3 amount of stickiness in their decision-making because
4 plans typically want to make the same decision for the
5 same plan, at least in a region. So, there are plan
6 level fixed effects in these equations to account for the
7 fact that plans try to make decisions across county
8 lines.
9 These are some selected results with respect to
10 the Herfindahl Index and there are four rows in this
11 table, and I would call your attention to the second row
12 and the fourth row. These are efforts to kind of
13 standardize the regression results to make it a little
14 bit easier to understand and to compare. The second row
15 is the predicted effect of a 10 percent change in the
16 payment rate. So, if the payment rate were increased by
17 10 percent, the probability of a plan charging a premium
18 would go down by 35 percent. That's a big effect.
19 To compare that, if the Herfindahl Index were
20 increased by 10 percent, the probability of the plan
21 charging a premium in that county would go up by 7
22 percent. That's a smaller effect than 35 percent,
23 certainly, but it's a significant effect nonetheless.
24 And if you look across the entire table, you see that, in
25 general, the effect of the Herfindahl Index was smaller

1 than the effect of the payment rate, but it's significant
2 and it's of meaningful absolute size.
3 In the one case of the probability of offering
4 drug coverage at all, that's the second column, the
5 Herfindahl effect actually is strong and significant and
6 the payment effect is not significant.
7 Here's some selected results for the so-called
8 other variables and, again, the second and fourth columns
9 make for easier comparison. And, again, the payment
10 rates are -- have strong and significant effects and the
11 other variables also have significant effects, but they
12 are substantially smaller across the board than the
13 payment effects, with the exception of the equation for
14 whether or not plans offer dental benefits. There, the
15 payment rates really didn't have much of an effect at
16 all. Although it was significant, it was very, very
17 small.
18 But what really explained all the variation --
19 well, not all the variation, but most of the variation --
20 in whether plans offer dental benefits was what other
21 plans in the county were doing. If there were any other
22 plans in the county that were offering dental benefits,
23 it had an effect of 57 percentage points on the
24 probability of offering dental benefits.
25 So, those are the results of the first study

1 and those firmly establish that industry concentration
2 and what other plans in the county are doing have strong
3 effects on what a given health plan in a county will
4 decide to do with respect to benefits and with respect to
5 premiums.
6 What about with respect to entry? We looked at
7 the entry decisions of the first private fee-for-service
8 plan. Private fee-for-service is a new option. The way
9 private fee-for-service works under Medicare Plus Choice
10 is they function under the same payment rates, they have
11 the same risk bearing, the same risk adjustment rules as
12 other Medicare Plus Choice plans, but they have much
13 lower entry costs than traditional HMOs because they
14 don't have to establish or maintain a network.
15 However, they're more potentially vulnerable to
16 adverse selection. This is because, as has been
17 mentioned before, traditional HMOs tend to get favorable
18 selection because of the restrictions that they impose on
19 utilization, choice of doctor. But fee-for-service plans
20 don't benefit from that. So, it would be reasonable for
21 the private fee-for-service plans to be concerned about
22 experiencing adverse selection and that might influence
23 their market entry decisions.
24 The only private fee-for-service plan that was
25 in existence in 2001 and early 2002 was offered by

1 Sterling Life Insurance Company. They entered in June of
2 2000 and they were in 25 states. By the spring of 2002,
3 they had about 20,000 enrollees and they offered coverage
4 similar to Medigap Plan C, which is one of the regulated
5 Medicare supplement indemnity plans. They don't offer
6 any drug coverage.
7 One of the questions or some of the questions
8 that we were thinking about that I think are relevant to
9 the discussion here is, does private fee-for-service
10 compete with HMOs in the Medicare Plus Choice Market?
11 What about with Medigap plans? Should these products be
12 thought of as existing in different markets? We had data
13 on all the counties in the United States. Again, our
14 unit of observation is the county. Sterling entered
15 about half the counties as of December of 2001. But they
16 were very small. The average number of enrollees per
17 county that they entered was six.
18 We estimated an entry model. What are the
19 factors that influenced entry? And an enrollment model
20 simultaneous with the entry model to see what factors
21 influence enrollment. Here are some selected results.
22 The first line is the HMO market penetration rate. So,
23 Sterling was clearly attracted to markets where HMOs were
24 established, where there was market penetration on the
25 part of HMOs, which was kind of interesting, since

1 they're not an HMO plan. It had a significant marginal
2 probability effect, which is that second column, but a
3 negative enrollment effect. So, they were attracted to
4 those markets, but they weren't terribly successful in
5 enrolling people there.
6 They tried to avoid markets where Medigap Plan
7 C premiums were high. That's the second row. But they
8 were successful in enrolling people there. So, this
9 isn't a big surprise. In counties where the alternatives
10 were expensive, they were successful enrolling. I should
11 say, Sterling, at this time, had one national premium.
12 The third line is the number of HMOs, Medicare
13 Plus Choice HMOs. If there were a lot of Medicare Plus
14 Choice HMOs, they tended to try to avoid that county and
15 in counties with a lot of HMOs, they weren't very
16 successful in enrolling people.
17 But in counties where the number of HMOs
18 changed and, in particular, in this time period the
19 changes were negative because HMOs were pulling out of
20 the Medicare market, so where the numbers of HMOs were
21 declining, Sterling tended to enter. Since the change in
22 the number of plans was negative, that negative .14
23 results in a positive effect on entry and they were very
24 successful enrolling people.
25 So, in this time period, one of the main

1 findings of the study is that as HMOs pulled out of the
2 Medicare market, Sterling targeted, either purposefully
3 or inadvertently, those markets and enrolled a lot of
4 people.
5 The last row there is the Herfindahl Index and
6 there's no significant result there, which we didn't look
7 at all that carefully at the time. But I went back and
8 looked and this is why. The way we defined the
9 Herfindahl Index was, if there were no HMOs in the market
10 -- since we originally built it thinking about the HMO
11 market -- the Herfindahl Index was zero. We could have
12 just as easily made it missing.
13 If you look at that graph, you see that there
14 is an interesting effect and it's an effect where the
15 Herfindahl Index, that second bar there is where the
16 Herfindahl Index is between zero and .5. So, those are
17 markets where the HMO market share is not heavily
18 concentrated or relatively less concentrated.
19 So, while Sterling was about 50 percent likely
20 to enter most counties in the country, they were less
21 than 25 percent likely to enter counties that had less
22 industry concentration in the HMO market, and that makes
23 sense. If the Herfindahl Index is a good measure of
24 competitiveness in the market, Sterling avoided
25 competitive markets because the opportunities there would

1 be less attractive.
2 So, in summary, the main findings are that
3 industry concentration affects premiums, benefits and
4 market entry. Medicare Plus Choice plans adjust premiums
5 and benefits in response to other Medicare Plus Choice
6 plans in the county. The effects of competitiveness
7 variables, industry concentration and such are smaller
8 than the effects of payment rates, but they're still
9 quite substantial. And private fee-for-service competes
10 with both Medicare Plus Choice and with Medigap plans.
11 Some points of interpretation, I think these
12 findings suggest that the markets for Medicare Plus
13 Choice insurance are small, probably bigger than
14 counties. Maybe MSAs are the appropriate market size.
15 Again, HMOs, private fee-for-service and Medigap all do
16 compete with each other for enrollees within these
17 markets. So, that would tend to argue for grouping them
18 together in a market. Arguing against grouping them
19 together in a market is the well-known fact that HMOs
20 experience favorable selection and private fee-for-
21 service, fee-for-service and Medigap plans tend to
22 experience adverse selection. So, that's a very
23 important difference in the way that they make their
24 decisions.
25 Finally, it's pretty clear from the evidence on

1 the Herfindahl Index that the markets are not competitive
2 in the sort of pure competition sense and that oversight
3 of mergers in this area would be justifiable. Thank you.
4 **(Applause.)**
5 MS. LEE: Next is Jon Gabel. Jon is the Vice
6 President of Health Research and Educational Trust. Jon?
7 MR. GABEL: Thank you. Let me begin by saying
8 that I speak here today as an independent analyst, not a
9 representative of Health Research and Educational Trust
10 or the American Hospital Association.
11 What I want to present today is different, I
12 believe, than the earlier presentations. I want to lead
13 with my data and I think that what this data will suggest
14 is that over the -- in the last couple years, the
15 insurance industry has become less competitive. And then
16 after presenting the data, I ask, as the Kingston Trio
17 asked to music 40 years ago, where have all the insurers
18 gone. And I'll try to answer that question.
19 Since we have such an esoteric audience here, I
20 read the sports page every day and I also read the front
21 page, but rather than tell you a story about Shaquille
22 O'Neal, I'm going to quote from Voltaire. And Voltaire
23 once observed that, "In a nation where there is one
24 religion, there is dictatorship; in a nation where
25 there's two religions, there's civil war; and in a nation

1 with 100 religions, there is peace." And we will have --
2 today, we have peace.
3 This is what I care to present today. I want
4 to review recent trends in health care costs. I want to
5 examine the underwriting cycle in recent years. This is
6 important because I believe the underwriting cycle is
7 largely determined by patterns of exit and entry. I want
8 to examine the pattern of entry into local insurance
9 markets and I want to assess why insurers have not
10 entered markets in recent years.
11 This is the history of health insurance
12 premiums since 1988. The survey is now the Kaiser Family
13 Foundation Health Research and Educational Trust Survey,
14 earlier done by KPMG and HIAA. I've just given you my
15 resume.
16 Let's just very quickly go over it. We hit a
17 peak of 18 percent in 1989. During this period of time,
18 indemnity insurance was about 70 percent of the market.
19 We have a growth of managed care during this period of
20 time. We hit a bottom of eight-tenths of 1 percent in
21 1996. This is the high water mark for HMOs, for heavily
22 managed care. At this time, HMOs had about 33 percent of
23 the market share, but not only did they have the 33
24 percent market share, they had narrower networks than we
25 have today. They had capitation, they had

1 preauthorization review, they had primary care
2 gatekeepers. I believe managed care was an economic
3 success. I believe, and you can disagree with me, I
4 think it was a political failure. And that is why we
5 have a kinder and gentler managed care following this
6 period of time.
7 And as we retreat, as we lose preauthorization,
8 as we lose capitation, as we go to broad networks, and
9 that's what's most important, you can see every year we
10 have a pick-up in the rate of inflation.
11 Well, premiums go up for two reasons. Number
12 one is the underlying claims expenses, but number two is
13 the underwriting cycle. And let's talk about the
14 underlying claims expenses. You can see the claims
15 expenses followed a similar pattern, not as volatile as
16 premiums, but here we fall from 6.9 percent increase in
17 claims expenses per year. During this period, '94 to
18 '96, we have approximately 2 percent a year which I
19 believe is the lowest we have ever had, if we could ever
20 go back to the '80s and the '70s. And you can see then
21 we've had increases every year since and it was to 10
22 percent last year.
23 Now, let's look at the components of the
24 increased medical expenses. I think prescription drugs,
25 the blue line, were persistently high, have started to

1 come down now due to three-tiered cost sharing. But you
2 can see they were in the 15 to 20 percent range for many
3 years.
4 Inpatient hospital expenses are most
5 interesting. During this period of very low inflation
6 from 1994 to 1998, we actually had nominal decreases in
7 hospital expenses per capita. If there's one thing
8 managed care was good at was keeping people out of the
9 hospital, and at that period of time, getting large
10 discounts from hospitals. You can see in recent years
11 there has been a big increase in hospital expenses. This
12 is due to both utilization. It is due very heavily -- as
13 a result of increased utilization, you have a shortage of
14 nurses, and we can see last year that the increase was
15 about 7.5 percent.
16 Now, this line right here, this is outpatient
17 hospital expenses. This actually includes ambulatory
18 surgery centers, which makes the numbers bigger. But,
19 again, you can see, we've had a very large recent
20 increase. This is also -- this is largely driven by
21 volume. The point again being that managed care, which
22 was able to control costs during an earlier period of
23 time, does not show the ability to control costs as we
24 had in that mid-1990s.
25 Now, let's go to the underwriting cycle.

1 Unfortunately, the most accessible data is from Blue
2 Cross/Blue Shield and it illustrates the cycle. You can
3 see that we went through this period of time, even in
4 '89, the Blues made money. They made money all the way
5 through '94. Then we go through a period of time where
6 their underwriting gains were negative.
7 Let me back up. When I say "underwriting
8 gains," I am talking about profits before investment
9 income. Now, since then, you can see that we are picking
10 up profitability. This 2.4 percent figure is for the
11 first six months of 2002. So, in other words, we have
12 four years now consecutive of underwriting gains. And,
13 of course, this does not, again, include profits from
14 investment income.
15 So, now, let's talk about why the entry and
16 exit of insurers. Now, what happens generally is after
17 years of profitability, insurers will enter new markets.
18 National companies will enter new markets. And during
19 this period here, there was very heavy entry of new firms
20 into new markets. In fact, I can remember back in '95 or
21 so, the belief was among the major insurers that only
22 four insurers were going to survive in each market and we
23 want to be one of those four insurers in each market.
24 Consequently, we had great entries, you will see in
25 subsequent graphics, during this period of time.

1 Now, of course, when insurers start losing --
2 when they enter these new markets, they compete very
3 fiercely through price. They price below the rate of the
4 increase in claims expenses and they all end up losing
5 money, which they did right here. Then they start
6 exiting the market. With fewer firms in the market,
7 they're able to raise their premiums and they're able to
8 start realizing underwriting gains. That is the health
9 insurance underwriting cycle, an underwriting cycle which
10 is also seen in other types of insurance, such as
11 property and casualty.
12 Now, how about the managed care companies?
13 These are the ones that are publicly traded. This data
14 are, actually, I think, from Lehman Brothers. I will
15 have to look again on that. You can see, in the last
16 four years, this was actually supposed to be 1.1 percent.
17 You can see the growth in profitability among the
18 publicly traded managed care companies, up from 1.1
19 percent to 4.4 percent. So, we do have a more profitable
20 industry after going through some pretty hard years.
21 At the same time, though, the managed care
22 companies are not earning as much on their investments.
23 They are like everybody else and the interest rates are
24 lower and you cannot obtain the same rate of return for
25 bonds and bills, et cetera, let alone if you invest in

1 the stock market.
2 Now, I'm going to very quickly summarize the
3 literature about HMO market structure and performance. I
4 talk about HMOs in subsequent slides, not because I don't
5 consider other lines of business important, but simply
6 because as I think was noted earlier by Lawrence, I
7 believe, there's more data available on HMOs.
8 Well, number one, we see through the literature
9 that greater numbers of HMOs and local markets leads to
10 lower premiums. There are economies of scale -- see,
11 I've got all my footnotes in the audience just to flatter
12 them, Ruth, see -- of 115,000 and we believe there are
13 economies of scale up to that point, but then after that,
14 they decline. Roger Feldman, he's in all these other
15 three.
16 Despite the many national mergers which took
17 place during '94-'97, this period of time was
18 characterized by increased competition in local markets,
19 which is one reason why we had that underwriting cycle.
20 Concentration of the HMO industry is growing nationally,
21 but it's local markets that determine the level of
22 competition. Now, given that as background, let's look
23 at the entry patterns in the last couple of years.
24 These are new figures. Again, it reflects the
25 underwriting cycle. You can see during the 1980s, we had

1 a period of time in the 1980s, around '84, '85, '86, I
2 believe, where there was profitability and there's a lag
3 effect and a little -- but you can see the big entry that
4 took place. Then we had a shake-out as the insurance
5 industry lost money in '86, '87, '88, the industry lost
6 money. You can see with the lag effect there was very
7 little market entry.
8 The industry now is earning money and you can
9 see that there's a little bit of a lag, but they start
10 earning in '89 and here, by '91, we're up to 11 and you
11 can see, during this period of time, the entry of new
12 HMOs in the nation. And now, as we go into -- the HMO
13 industry is losing money. There is no entry. And now,
14 we're starting to earn money again, but we will have
15 virtually no entry during the last couple of years.
16 That's national statistics.
17 Let's just say, why should we be expecting HMO
18 entry at the local level? Number one, we've had four
19 years of underwriting profits, although there's a lag --
20 at this point, I would expect historical patterns, we
21 would find some entry. There's growing profitability
22 among the publicly traded MCOs and there's a limited
23 number of competitors in many local markets. There's
24 low-hanging fruit. For example, Norfolk, Virginia, which
25 had about 10 effective competitors back in the 1995-1996

1 period, as of about two years ago, there were two
2 effective competitors. And so, again, low-hanging fruit.
3 So, let's look at it on a per state basis.
4 Look what happened in 1996 compared to 2001. You can see
5 in all the states we have a decline in the number of
6 licensed HMOs. Look at Illinois. What a sharp decline
7 it had. Maryland, sharp decline. Maryland has a big HMO
8 penetration.
9 If we look at Massachusetts, big HMO state.
10 You see a big decline in the number of HMOs competing.
11 Minnesota, a slight decline, big HMO state. Big decline
12 in New Jersey. We looked earlier at how we picked up
13 market share in Atlantic City. I wonder how many of
14 those HMOs are still in business. You can pick up market
15 share and lose a lot of money. That's one thing we know
16 about the underwriting cycle.
17 Ohio, look at the very significant decline.
18 Virginia, I'm aware of. Norfolk, for example, a very
19 significant decline in the number of HMOs. And a big HMO
20 state like Wisconsin has far fewer licensed HMOs. So,
21 here we have fewer firms competing. The result is,
22 according to the literature, we can expect premiums to go
23 up more than they would if we had more firms competing,
24 and we have had premiums increase.
25 Now, this one I have -- in this graphic, I have

1 put the entry of new commercial HMOs alongside of the
2 Blue Cross/Blue Shield underwriting gains and losses.
3 And you can see there's generally a little lag.
4 Historically, we have a little lag, but they do tend to
5 follow one another. If you're not earning money, you get
6 out of the market. If there's opportunity to make money,
7 you go into the market. There was, historically, sort of
8 a free -- a relatively easy -- ease of entry.
9 Now, we have a recent increase in underwriting
10 profitability, yet we have no indication of any entry
11 into the market. And I have talked to a number of large
12 national plans and they do not indicate any interest in
13 entering local markets.
14 Now, let me say this, what might be different
15 today? Why not? Well, I think, first of all, many of
16 the insurers got badly burned in the 1990s and they have
17 long memories now. Wall Street is leary of MCOs with an
18 aggressive entry strategy for the same reason. Now, this
19 is what I think is most important. I think the cost of
20 entry is greater today than it was 20 years ago or 10
21 years ago.
22 Let's go back 20 years ago. Twenty years ago
23 you had an indemnity plan, all you needed was a license.
24 You didn't have to have a network. You didn't have to
25 worry about quality assurance, utilization management, et

1 cetera. Ten years ago, you could enter a new market and
2 you only had to sign up one-third of the hospitals.
3 That's good enough. That's all you needed to do.
4 Today, employers want a wide network. You
5 essentially want to have to sign up everybody, or at
6 least come close to that. And this requires greater
7 purchasing power. So, if I try to enter a new market,
8 unlike 10 years ago, I don't have the purchasing power
9 and one-third of the hospitals isn't good enough and I
10 think there's provider push-back. The provider push-
11 back, I think, makes it more difficult to secure the
12 substantial discounts, and I think many of the health
13 plans are making big capital investments in information
14 systems, which is making entry a little more difficult,
15 also.
16 Conclusion. Again, I depart with a question
17 rather than an answer. I say, why now, after four years
18 of profitability, why is it we see almost no movement
19 whatsoever into local markets. And, of course, if HMOs
20 do not enter new markets, the last round of inflation is
21 -- the current round of inflation is likely to last
22 longer, we'll have less innovations as new firms enter
23 markets and we'll have less aggressive behavior on the
24 part of health plans to control cost.
25 Now, as I started with Voltaire, let me end

1 with two quotes, also. The first one is from Adlai
2 Stevenson. He once observed, "Man does not live by words
3 alone, although sometimes he does have to eat them." I
4 hope I will not eat mine.
5 And, number two, I have given you many
6 statistics. I ask you to think as your very last thought
7 of the day, think of what George Bernard Shaw once said
8 which was, "Only a truly educated person can be driven to
9 tears by statistics."
10 So, I ask you to look on your left and look on
11 your right and I thank you.
12 **(Applause.)**
13 MS. LEE: Thank you. Fred Dodson, who is Vice
14 President of Network Management at PacifiCare of
15 California. Fred?
16 MR. DODSON: June, since I don't have Power
17 Point, do you mind if I just sit here and work off my
18 notes?
19 MS. LEE: No, please do whatever makes you most
20 comfortable.
21 MR. DODSON: Well, in answer to Jon's question,
22 where have all the insurers gone, my response to that
23 would be, “Do you know the way to San Jose.” But I'll
24 get back to that. My name is Fred Dodson. I'm Vice
25 President of Network Management of PacifiCare of

1 California. In insurance speak, that means I manage the
2 relationships with the provider community most
3 prominently, but I spend probably the other 50 percent of
4 my time working with large employers and working with
5 medical management issues.
6 PacifiCare of California is the largest
7 operating entity within a company of PacifiCare Health
8 System. We have about three million members across
9 PacifiCare Health Systems, operate in a number of western
10 states, Washington, Oregon, California, Nevada, Arizona,
11 Texas, Oklahoma and Guam. I think I got them all right.
12 In that three million members, we have
13 approximately 700,000 M+C lives. Additionally, we've got
14 about nine million members nationwide in specialty
15 products, pharmacy benefit, vision, dental and behavioral
16 health.
17 The comments I have I'm giving to you from a
18 large insurer's perspective and I'll address them in four
19 general areas, those being market concentration, the
20 purchaser product preferences, market tensions and the
21 provider issues, and the regulatory and political
22 impacts.
23 In terms of market concentration, very clearly,
24 where I spend my life, there is a lot of competition.
25 And I think it's important to note that while there are

1 multiple insurers, when you look at information on HMOs,
2 that speaks only to HMOs. In the markets I have broadly
3 broken out, there are HMOs, there are PPOs, there are
4 point-of-service plans, there are now consumer-directed
5 plans. But within each one of those categories, you
6 might have five, 10 to 20 or 30 different opportunities.
7 Just within our HMO offerings in California, we probably
8 now have at least three or four very major differences in
9 the plan types, and then you can get down to smaller
10 differences in terms of out-of-pocket co-pays and other
11 variables. And if you take that to the PPO arena, you
12 only expand upon it.
13 So, there are numerous options out there to the
14 employer level of purchase and the employer level of
15 purchase is an important distinction that I'll get back
16 to.
17 The other thing is many large employers simply
18 can self-fund if they desire to. So, that's an
19 additional choice.
20 The other thing we've seen in California, that
21 when we find competitive advantage, when we enter the
22 marketplace with a new product, that competitive
23 advantage is usually fairly short-lived because our
24 competitors will respond meeting employer expectations
25 and come up with a product that is comparable.

1 One other thing worthy of note as you look at
2 this is most employers can purchase differently across
3 different geographic areas. So, I may opt to have
4 PacifiCare as an employer in Northern California, Aetna
5 in Southern California, somebody else in Arizona. It
6 doesn't force me to make a decision across multiple
7 markets when I make an insurer decision.
8 So, when we look at it, you know, we haven't
9 seen that mergers really have resulted in a unilateral
10 competitive effect. That's not where we've seen this
11 play out so far. In fact, we've got some real life
12 experiences in PacifiCare as a company and we did a
13 little looking. We went back and looked at the Lehman
14 study. Only three of the 32 mergers or acquisitions
15 we've seen in recent years were even within the same
16 geographic marketplace. And it's important to understand
17 that health care as a product, which I'll get into a
18 little more in a minute, is purchased locally and the
19 consumer of the health insurance is purchasing a health
20 care product much more than they're purchasing insurance.
21 Our examples, FHP was a merger of essentially
22 equals. When PacifiCare and FHP merged in 1997, we
23 subsequently, at that time, faced a number of challenges
24 that I think we've finally worked our way through. But
25 we had to compete in a very active marketplace in all

1 those areas in the midst of putting together a merger and
2 we learned that mergers are not easy work.
3 In Northern California, we've lived with a
4 couple of experiences in the last year with our
5 competitors. Health Plan of the Redwoods was a health
6 plan, predominantly HMO, some Medicare business,
7 operating in Sonoma and Napa, Mendocino and some of the
8 other Northern California counties. They were the most
9 successful, from the consumer standpoint, and profitable
10 health plan. They didn't have the highest profit margin,
11 but they were profitable in that market until they faced
12 significant provider pressure on the premium equation.
13 Basically, the provider community came back and said, we
14 need more resources.
15 The ultimate effect of that was Health Plan of
16 the Redwoods closed about six or eight months ago. Any
17 one of the insurers in the marketplace could have bought
18 that health plan for essentially nothing. No one did.
19 The plan simply closed. The only effect of that closure
20 was the premiums have increased in that market with all
21 the competitors. There's at least five significant
22 health plan competitors in that market. Premiums have
23 increased almost identical to what the payment rates of
24 the provider community have increased. It's simply what
25 has happened in the cost equation.

1 Down in San Jose, Lifeguard, another regional
2 health plan, had 150,000 members, was actually one of the
3 dominant health plans in that marketplace, closed its
4 operations about six or eight months ago. Same
5 situation. No one stepped up to the plate, no
6 acquisition. It was simply allowed to dissolve. And the
7 premium rate increases in that marketplace essentially
8 mirror the premium rate increases in the rest of the
9 market area.
10 Let me transition and take you through the
11 purchaser product reference. Clearly, the employers set
12 the expectation for us on what the product is. So, we
13 design products to meet employer expectation and a big
14 piece of our product is what is the provider network.
15 It's gotten to the point where the employer expectation,
16 the consumer expectation have driven us to the point to
17 where we're a very close substitute for the other 10, 15,
18 20, 30 opportunities for that employer in a given
19 marketplace.
20 That doesn't mean we don't attempt to
21 distinguish ourselves and make ourselves distinct from
22 others. We'll work on doing that by branding, cost,
23 quality, different product types. But over time, that
24 all just blends back to our competitors matching us.
25 Let me give you an example. CalPERS in the

1 State of California -- in terms of what happened with the
2 major purchasers. CalPERS covers about 1.3 million lives
3 in the State of California. About almost a year ago now,
4 Blue Shield became the sole major insurer for CalPERS in
5 the State of California. That became effective on 1/1 of
6 this past year. But that business was put out to bid.
7 HealthNet and PacifiCare were both major
8 insurers with CalPERS. The result of the lower bid with
9 Blue Shield was that CalPERS went to Blue Shield.
10 HealthNet and PacifiCare no longer became insurers for
11 that population of employees. That affected about
12 300,000 lives who were with PacifiCare or HealthNet. And
13 CalPERS own estimate of the situation was that 90 percent
14 of the employees would be able to retain their same
15 physician and same hospital as a result of switching
16 insurers.
17 The other interesting thing -- I'll get back to
18 it -- did this really change the purchasing power of Blue
19 Shield in the community when it is purchasing services
20 from hospitals and physicians? The first assumption you
21 would have is yes. The facts, we believe, would prove
22 out to be no as I get to characterizing the effects I
23 face with a major health system that exists in Northern
24 California, maybe this will make sense to you.
25 On the third area of market power, hospitals

1 and physicians, let me describe for you that large health
2 system and the reality I face every day. A single health
3 care provider system in Northern California receives 40
4 percent of the dollars we pay out in health care services
5 in Northern California, approximately $500 million a year
6 and we influence that marketplace with approximately
7 400,000.
8 Now, the logical assumption would be that that
9 would give us, the insurer, significant purchasing power.
10 Reality is absolutely the opposite of that. That
11 supplier, that health system, has 26 hospitals, 13
12 medical groups, a number of ancillary services, lab, home
13 health, the whole array of health care services, that
14 they offer to us on an all or none basis. If we want one
15 of their hospitals, we take all 26. If we want one of
16 their medical groups, we take all 13. And the bottom
17 line is, we simply cannot offer a product in that
18 marketplace without that organization. We're not in
19 business without that.
20 And the reason for that is the consumer
21 transaction is a transaction of is my doctor, is my
22 hospital in your program. The consumer of the product
23 looks at this differently than the employer. The
24 consumer goes down and says, I want my doc, I want my
25 hospital, that's how I make my decision. So, we face

1 both an employer expectation that you must have this
2 health system in your health plan or we can't offer you
3 product and an individual consumer expectation of, is my
4 doctor in the program.
5 So, it plays out to an interesting provider
6 strategy to manage in this environment. The provider of
7 the large health system knows that. They approach us on
8 an all or none basis. Want one part of us, you have to
9 take all of us. Can't break it up. We're required to
10 offer them in all geographic areas and they cover
11 multiple markers across Northern California. So, if I
12 want them in Sacramento, I have to have them in Oakland.
13 They also recognize that there's a regulatory
14 requirement upon us that we are required in our HMO
15 products, at least, to provide adequate access. In many
16 places, we don't have adequate access to physicians and
17 hospitals without this organization. So, you can
18 leverage one market area where you have to have adequate
19 access now across multiple cities in Northern California
20 in an all or none approach.
21 One of the more interesting and insidious
22 things that this system has done -- and this is not the
23 only system we face this with in California, but this
24 particular system approaches us in a concept that we
25 lovingly call equal treatment. They state that they must

1 be equally treated, vis-a-vis all their competitors. It
2 seems innocuous enough. Take that to the level of the
3 individual consumer. That means if this health system is
4 paid twice as much by us as their competitor health
5 system we cannot have the individual consumer see a
6 higher co-pay for that system than for the lower priced
7 system.
8 Think about that. We're trying to put into
9 this industry some consumer transparency to cost and
10 quality. That contracting strategy has removed that
11 transparency. It's obscured. And at the point of the
12 individual consumer, they see no price difference between
13 a high cost health system and a low cost health system.
14 Interestingly enough, the same system attempted
15 to do that on quality, but they probably weren't forward
16 thinking enough. PacifiCare now has a hospital quality
17 index published in California on 50 publicly available
18 measures. Generally, in the hospital community it
19 presented some interesting challenges because the
20 industry had concerns about that type of information
21 being out there. This one particular system wanted
22 originally to be able to approve the information before
23 we distributed it. They had not covered that in the
24 contract, so we're able to avoid that.
25 Now, one more place to carry that through. As

1 these health systems have consolidated, if I am the lower
2 priced competitive health system in those markets, what
3 benefit is there to me? I, as the insurer, have no way
4 of passing that lower price benefit through to the
5 consumer because the larger more dominant system says you
6 can't show that to the consumer. The less dominant
7 system goes, well, there's no reason to be more price
8 competitive with the insurer than the big guys, I will
9 just move my price up. And, in fact, that's exactly
10 what's happened now in those markets and the less
11 dominant system has said it wants the other guy's rates
12 without using their name.
13 So, it's become -- we jokingly describe it as
14 kind of the rising tide raises all boats phenomenon. The
15 weaker systems rise to the higher price. There's no
16 reason not to.
17 It's fairly recent, actually, in health care --
18 if you go back a few years in this industry, physician
19 organizations influenced the market on the hospital side
20 and helped in the purchasing decision, but as the systems
21 have not only aggregated hospitals but aggregated
22 physician organizations on their behalf, the doctor now
23 no longer is influencing the cost equation. They are
24 very much married up to the health system that they are
25 an employee of or represented by in contracting. So, our

1 ability to use the physician to shift behavior and move
2 care is significantly limited by this contracting
3 structure. And, in fact, we are prohibited in contract
4 language from even encouraging physicians to direct care
5 to the lower cost facility.
6 Let me move on. A couple comments on the
7 regulatory and the political environment. Certainly,
8 mandated benefits, that is something that's commonly a
9 factor we deal with, has driven some of the similarity of
10 health plans. Now, that's not all bad by any means. But
11 there's a balance in this that you can tip the balance in
12 the regulatory and political environment to result in
13 unintended consequences. Let me give you an example of
14 one.
15 The Department of Managed Health Care in
16 California now regulates the HMO industry. They are
17 compulsive about access and quality and the types of
18 things you would want them to be compulsive about. But
19 where it plays out as an unintended consequence is, if we
20 wish to move members from a physician group as part of
21 this big system to someplace else, we weren't able to get
22 a contract, whatever reason, there's a quality concern,
23 we're unable to do that without the approval of the
24 state's Department of Managed Health Care. Why? Because
25 we have to ensure access and quality, et cetera.

1 Well, it plays right into the hand of the
2 dominant health system who says -- they contractually
3 tell them they can't move. They've also got a regulatory
4 prohibition. So, that regulation has made it very
5 difficult for us to work in a marketplace. I'm sure that
6 was not the intent of the Department of Managed Health
7 Care when the reins were put out there, but that's how it
8 plays out.
9 Other states we've seen, we live and operate in
10 Texas where over the past few years seven managed care
11 plans have left the M+C program in Houston. You know,
12 that certainly isn't desirable from the standpoint of the
13 government. A lot of that is just due to the business
14 and regulatory and political and other environments that
15 have existed in that state.
16 In closing, you know, let me say I come from
17 this from a perspective of having lived all sides of this
18 life. I don’t want you to think that I've made comments
19 about the provider system and I've never spent any time
20 in the provider system. I spent half my life as a
21 hospital CEO, health care system exec, et cetera. I
22 understand the system from that perspective. I think
23 it's a wonderful thing that we have done what we've done
24 in health care, we can transplant organs, we can do
25 things that we never even imagined when I got into this

1 business 25 years ago.

2 But it's now a system with a lot of subtle
3 issues that sometimes it can be missed, and I think a
4 very clear shift in the balance of power of many markets
5 that are driving health care costs, that may not be seen
6 unless you're living them on a day-to-day basis. With
7 that, I'll conclude. Thank you.

8 **(Applause.)**

9 MS. LEE: Helen Darling is President of the
10 Washington Business Group on Health.

11 MS. DARLING: I'll stay seated, too. I think
12 you'll hear that Fred and I didn't plan this, but I
13 pretty much see the world as he's described it from the
14 national perspective. We find that our large employers
15 find vigorous competition among health plans and most
16 employers feel that the health care system falls short on
17 many dimensions, including competition, generally. But
18 health plans and insurance and that piece of it works
19 better than other parts of the system, which is not to
20 say they're perfect. But at least in terms of the
21 question at hand, there's plenty of competition from the
22 point of view of especially large employers.

23 In general, as Fred said, large employers,
24 first of all, in any market they're in, they have a lot
25 of options. I have enormous respect for Jon Gabel's

1 research and data, but it’s also true that we look at a
2 given community and HMOs are a relatively small part of
3 the community and we have more people in PPOs and other
4 things than HMOs. So, you can’t imagine the geography of
5 a given region and not think of all the things that are
6 there and there are point of service plans, there are
7 HMOs, there are PPOs, there are all these things that we
8 haven’t even named yet, but will undoubtedly emerge.
9 There are consumer-directed health plans.
10 It is a very, very complex collage of options
11 and most employers are, in fact, moving in those
12 directions pretty quickly. If you look at just the data
13 on HMOs alone, real HMOs -- and then, by the way, I would
14 say, again, not to, in any way, Jon’s data, but I know
15 those markets, I used to run the benefits at Xerox
16 Corporation. I had people in every one of those markets.
17 I can tell you there were states there that, in my mind,
18 I wouldn’t count them for having a single HMO. Certainly
19 not any real managed care.
20 Now, they may have had a license, but they were
21 basically what I call fee-for-service in drag. They just
22 were prepayment overlaid on an existing crazy system.
23 And you had a little prepayment and you -- maybe if you
24 were lucky, there was a little bit of pre-certification
25 or something, but there wasn’t real management. These

1 weren't integrated systems. These weren't systems that
2 had sort of the kinds of things that PacifiCare has,
3 where you have actually people who are sitting there
4 trying to figure out what works, what doesn't, what
5 should we encourage people to get, what information we
6 should provide for them.
7 So, in most places in this country, even when
8 we had managed care all over the country and even when we
9 had people in HMOs, we really didn't have a nation full
10 of real managed care. So, I think that's important to
11 keep in mind. It's even getting more complicated. But
12 for my large employer members -- and we are a business
13 group of about 175 mostly large employers and most of our
14 employers are all over the country. In fact, many of our
15 employers are all over the world, although they generally
16 don't deal with health care outside of the United States,
17 at least in terms of the delivery system.
18 Most of our members have a handful, anywhere
19 from one to three or four national plans that they use to
20 essentially ensure that everybody in the country at least
21 has a fall-back plan if they happen to be in an area
22 where -- and it's usually a self-funded plan that just
23 covers care where it's needed in rural areas and things
24 like that.
25 They also, in every market -- in fact, the most

1 successful ones, in fact, go in and do a market-by-market
2 analysis and they use information about what the options
3 are to figure out what they want to do. So, there's a
4 lot of competition.
5 In addition, if you will, as sort of a last
6 straw even today, our large employers can just decide to
7 get totally out of the business of dealing with health
8 plans. They can self-fund. They don't even have to buy
9 stop-loss. They can self-administer and there are
10 companies who do that. They can rent networks. They can
11 rent anything they want to rent. So, if they got really
12 unhappy, you know, they could basically put it together.
13 Now, most of them don't do it, but I can assure
14 you that when you're sitting down every year looking at
15 what your costs are and some of the carriers come in and
16 say, sorry, folks, it's going to go up 18 percent this
17 year, they can, in fact, go back and say, well, okay, at
18 18 percent, at a per employee, per month fee of $27 for a
19 point of service plan they might say, okay, I think I can
20 do better. I can put in a PPO, I can change the cost
21 sharing, I can do a few other things. I can even, you
22 know, negotiate with a low-cost TPA and just move away
23 from what I've been doing. So, there's a lot of
24 competition, as Fred said, in -- now, that's not to say
25 there might not be a few individual markets. But,

1 frankly, the big markets, like everything else, all the
2 people are there, there are a lot of options there, and
3 in some of those big markets, there are even individual
4 like TPAs that run small funds and things like that.
5 You may not even want to do that, but as long
6 as you have that option you can and it makes the
7 difference in how you can negotiate.
8 In addition, though, I think large employers'
9 ability to contract is also -- because there is
10 competition and because there are different options, they
11 can go in and they can move business around in a way and
12 they do that a lot. Now, you might say, well, that's
13 large employers, sure, they get to do that. Well, small
14 employers usually don't have as much flexibility and they
15 are more influenced by the geographic area.
16 But, for example, I have been -- just one
17 example, the State of Connecticut, which I know well
18 because we were headquartered when I was at Xerox there,
19 and I used to have to take -- after COBRA ran out and the
20 kids hadn't gotten a job yet, I used to have to help them
21 get health care all over the country. So, I got to know
22 the individual markets through the children who had aged
23 out of the plans, as we said, but still hadn't gone to
24 work. And you find what's available and it varies by
25 state obviously.

1 But, for example, in Connecticut through CBIA,
2 which is the Business and Industry Association, you can
3 get actually a lot of plan options as an individual and a
4 small employer because they happen to have a pool that
5 does it that way. And the rates are very good because I
6 had to check out the rates, too.
7 So, I think there's more competition out there
8 at the plan level then there is probably in many other
9 areas.
10 Now, large employers' biggest concern in all of
11 these areas -- and this is a message and fortunately I
12 think PacifiCare generally does a certainly much better
13 than average job in this regard. So, I would exempt them
14 and a few others from this. But as large employers, we
15 have looked to health plans to be our partners in helping
16 to drive the transparency and information agenda forward
17 so that we have the information, that everybody has the
18 information, not just purchasers but consumers as well.
19 And partly for some of the things Fred talked
20 about, the power of the hospitals and the physician
21 groups, there has been a kind of stonewalling of
22 information. We've known for 30 years how to actually
23 put information out that's useful. In fact, for those of
24 you who have been around this town for a long time, you
25 know it was the '70s when the federal government, in its

1 wisdom at the time, actually passed a program to collect
2 and report health information on utilization.
3 Today, the QIOs, their grandchildren and great
4 grandchildren, whatever we want to call them, actually
5 have online a lot of information that's simply not
6 available to the public, partly because they don't know
7 how to get to it. So, we hope the health plans and the
8 insurance companies would work with us more to allow us
9 to have information. We have an imperfect asymmetric
10 information market. Transparency is a critical
11 ingredient in everything we're all trying to do.
12 And one of the nice things about transparency
13 in the system is it doesn't matter which side you're on,
14 everybody will benefit from transparency and information,
15 whatever the philosophy, whatever the position, whether
16 it's a consumer-directed world or purchaser-directed
17 world or even a physician-driven world, whatever,
18 transparency will work. So, we would hope that we could
19 all together drive the agenda forward and make certain
20 that we all have the information we need.
21 We also, I think, as an organization, as a
22 group of employers, we want to applaud the FTC and the
23 Department of Justice for what they're doing in health
24 care. It is about $1.5 trillion as I'm sure everybody
25 has said. It's soon going to be 2.8 and I think it's

1 going to go up no matter what, by the way. Most of the
2 things that are driving it are underlying forces to do
3 with medical treatment and utilization. And while all of
4 us, including I could do this, too, and would love to
5 have the opportunity to nitpick about a lot of things
6 about what's going on in the health system, the fact of
7 the matter is, even if we got everything solved and did
8 it very well and we had great competition, we had great
9 other things, we have a system that is being driven by
10 forces that have to do with utilization of health care.
11 And until, as far as we're concerned, until
12 consumers have information about that and a financial
13 incentive -- and it breaks my heart to hear what they do
14 in California -- a financial incentive to pay attention
15 to what these things cost and make decisions accordingly,
16 we're going to all be sitting up here looking at probably
17 a $3.8 trillion economy and half everybody's pay package
18 in America will be for their health care benefits and the
19 other half will be what they try to live on.
20 So, with that, I look forward to some
21 questions.
22 **(Applause.)**
23 MS. LEE: Let's take about a 10-minute break
24 before we start with the questions. Thank you.
25 **(Whereupon, a brief recess was taken.)**

1 **(Microphones not turned on to start Q&A**
2 **session.)**
3 MS. LEE: Jon?
4 MR. GABEL: I just want to make the point that
5 for -- as I indicated earlier, I showed HMO data because
6 HMO data are available. The other point is that most POS
7 plans have HMO licenses. So, it really shows -- if you
8 add HMO and point of service, you've got about 44 percent
9 of the market or something like that. So, it would be
10 indicative of, at least, 44 percent of the market and, of
11 course, most of the national players, if they have an HMO
12 plan, they have a PPO plan, et cetera.
13 The other point I just want to make is about
14 barriers to entry. There was much discussion about being
15 self-insured. The problem still is the network. Where
16 do you get the network? You need the network and you
17 need the discounts. So, maybe you end up having to rent
18 a network which is able to obtain big discounts. So, you
19 might end up, rather than having Aetna risk business,
20 Aetna self-insured, where you still are entering that
21 Aetna network.
22 So, if you are in Norfolk, Virginia and you
23 only have two real carriers who are getting big discounts
24 -- this is what the brokers that I work with say. It's
25 very difficult, even in the self-insured business, to

1 enter that market.
2 MS. LEE: Helen?
3 MS. DARLING: Yeah, just on that point. There
4 are a number of PPO discount networks that are
5 independent and are not connected with an insurance
6 company. So, you can do that separately. If what you
7 want is a -- you know, if you want to have a PPO plan or
8 you even want to have a discounted fee-for-service plan,
9 you can do that by buying the networks independently.
10 MR. GABEL: Such as Beech Street.
11 MS. DARLING: PHCS.
12 MR. GABEL: But generally they don't get as
13 substantial discounts.
14 MS. DARLING: Oh, I disagree.
15 MR. WU: Well, I just wanted to comment, Jon.
16 We really do have peace on this table. But what I was
17 going to say, that does mask a lot of churn.
18 I found your data interesting because it really
19 did seem to show that there was a lot of entry and exit
20 and fundamentally, it shows that the conditions for entry
21 and exit are in place. It seems to me that -- and this
22 is more a question for you. It seems to me that where we
23 probably disagree is when we expect new entry to begin
24 again because it sounds like historically we've seen
25 health plans respond to market conditions and enter new

1 markets when they think there’s a profit opportunity to
2 do so.
3 Your only complaint, it seems to me, is that
4 you haven’t seen it yet when you think you should have,
5 although you do say that entry costs are a little bit
6 higher. Is this a matter of time or do you really think
7 that entry is not going to occur?
8 MR. GABEL: Well, you have my point. My point
9 was that historically entry has been very easy. Now, for
10 some reason, it seems to be more difficult. I guess I do
11 eventually expect to see some entry, but I know I’ve
12 talked to a number of the CEOs of the large national
13 carriers and they seem to be dismissing entry at this
14 time out of hand. So, the lag is going to be a number of
15 years it looks to me. We’re at least two years away from
16 that.
17 MS. DARLING: A couple of things. What they
18 would buy into is so different. They cannot possibly
19 look at any market in this country and think they’re
20 necessarily going to make any money if they move into it.
21 That’s just going to be much harder to get them no matter
22 what because they don’t think they can make money in it.
23 One of the reasons they can’t make money in it
24 is because they, themselves, in spite of the fact that
25 they’re doing better now, they were in terrible condition

1 and their market capitalization -- I mean, just to give
2 you one example, the total market cap -- there may be
3 somebody in the room that knows the exact details -- of
4 Aetna, probably today, but certainly last year, was lower
5 than what they paid for U.S. Healthcare alone.
6 So, you've got giant companies sitting on very
7 weak assets and reserves and their ability or their
8 interest, therefore, to go into markets that are -- you
9 know, where there's any chance of losing more money is
10 just completely different. Not only is it not venture
11 capital, but everybody is financially risk adverse today
12 in a way that they weren't just a few years ago.
13 Now, you would argue that there were a lot of
14 bad business decisions made a few years ago, and some of
15 us are on the record of having said that numerous times,
16 but the fact of the matter is, today, they're in a very
17 difficult position regardless of what they'd be buying
18 into. Financially themselves, they are not strong.
19 MR. WU: Plus, in terms of new entry, I'm not
20 sure that we might actually see it with the HMOs. As
21 Fred said, PPOs are really what consumers are preferring.
22 I'm not sure whether we see more entry there.
23 MR. DODSON: The product request of the
24 employers right now are not heavily focused on HMOs.
25 We're in that cycle where we're into choice and

1 flexibility and all those other dynamics you showed, and
2 that is the PPO product or other new products rather than
3 an HMO. So, in fact, we're entering a number of markets
4 for PPO, but there's no way we would enter those markets
5 for HMO right now because that's not what we're being
6 requested to do.
7 MS. DARLING: Right, exactly.
8 MS. LEE: I want to ask -- well, let me just
9 follow up a little bit on what the discussion has been
10 about. This question of new entry and when and how entry
11 will begin again, there seems to be diverging opinions on
12 the panel as to how easy entry is. I guess my question
13 would be, well, there may be lots of competition now.
14 We've heard this from both Fred and Helen, there's lot of
15 competition now.
16 My question would be, well, what would happen
17 in the face of a merger? Would we still expect to see an
18 equal amount of competition? Is there some point where
19 we would expect to see there to actually be competitive
20 effects? And to follow up on that a little bit,
21 certainly as Lawrence has stated, we would expect to see
22 that entry could defeat any competitive effects that we
23 might see and to what extent do the provider contracting
24 issues that Fred discussed affect ease of entry or how
25 does that affect how easily a company may enter?

1 MS. DARLING: I'll start on that one. I'm sure
2 everybody has a comment.
3 MR. MAZZEO: June, I can start on --
4 MS. DARLING: Go ahead, that's fine.
5 MS. LEE: Okay, go ahead.
6 MR. MAZZEO: I'm sorry.
7 MS. LEE: Go ahead, Mike.
8 MR. MAZZEO: Okay. I think that that question
9 is particularly germane in context because when we're
10 thinking about potential entrants into a market where a
11 lot of the commentators already believe that the market
12 is competitive, that the issue of potential entry is not
13 as important. But if we think that entry is difficult,
14 then we have to take merger policy a lot more seriously
15 to the next level because it's potentially difficult to
16 have new firms respond if, subsequently, to a merger
17 there is supra-competitive profit.
18 Lawrence was mentioning earlier the period of
19 time where supra-competitive profit can be earned is
20 what's important and that goes to the question of whether
21 entry -- it is more or less possible into these markets.
22 So, I think that those two issues, merger policy and
23 potential entry, are linked really closely together.
24 MS. DARLING: It very much depends on how it
25 is. I mean, this is so obvious I hate to state it. But

1 you have four or five really big carriers around the
2 country. If United, Aetna and Cigna all merged, that
3 would be one thing. If, you know, HMO X down in River
4 City in rural Texas merges with something, it wouldn't
5 matter at all.
6 So, it's really important who it is and this is
7 no surprise, but there will be markets where you have
8 five and six and seven large plans already operating, and
9 if anybody was doing well, there may be more that come
10 in. But they are going to all be pushed by the same
11 provider pushback that Fred talked about. So, they're
12 all going to have fixed costs that, in our judgment, is
13 too high to start with.
14 MS. LEE: Lawrence?
15 MR. WU: I guess my answer would involve a
16 summary of some of the points that other people have
17 made. If I looked at John's charts, what I would
18 conclude is that there really has been a lot of entry and
19 exit, which would suggest to me that the costs of
20 entering and exiting a market are relatively low. So,
21 it's not really the likelihood of entry that would be an
22 issue in evaluating a merger.
23 I would also -- and then in terms of the study
24 or the graph that I showed, I also think that entry is
25 likely to be effective in disciplining an incumbent

1 health plan and I think that has been borne out
2 historically. So, to me, I'm not troubled by the
3 effectiveness of entry or the ability of an entrant to
4 discipline pricing.
5 So, really, I think where that takes me is
6 there is a policy question for, I think, the agencies
7 which is, are you willing to rely on entry when you know
8 that on its face, shares are likely to be high. That's
9 sort of the 30,000-foot policy question. But the ground
10 level question really goes to something that Helen just
11 raised and really an implication from Mike Mazzeo's work,
12 which is when we think about entry, how much do we really
13 care that the new entrant is likely to be someone that's
14 a close competitor to an existing pair of competitors.
15 And, obviously, with merger work, we do both. We look at
16 things at the ground level.
17 But I think here an important policy question
18 is, is whether we can count on entry, and I think we
19 really can count on entry especially if we define markets
20 more narrowly. The more narrowly you define a market,
21 the more entry becomes an important question. The
22 broader you define a market, it's not so much entry
23 anymore. But anyway, I'd just raise those two comments.
24 MR. HYMAN: I've got a couple of employer-
25 related questions and I'll start with one at a time, I

1 guess. The first question really is, how big does an
2 employer have to be to have unbundling of the insurance
3 product as a credible threat to deal both with the
4 insurance company and downstream purchasing from health
5 care providers? And the overlay on that is, does the
6 availability of the services necessary to unbundle vary
7 across geographic markets? I mean, is it easy to get in
8 New York City and hard to get in West Texas?
9 I mean, I think a number of the panelists can
10 take a whack at that. I actually think it's Fred,
11 Lawrence and Helen, but everybody else can chime in.
12 MR. DODSON: Well, if you're going down the
13 path of the self insurance alternative through the --
14 MR. HYMAN: Well, I mean, it's not limited to
15 self insurance, but that's the sort of endpoint of the
16 continuum. I mean, Lawrence, I think, outlined a range
17 of unbundling options that, you know, start at one end of
18 the spectrum as buying a state-regulated insurance plan
19 and at the other end is self-funded and anything where
20 you administer it yourself.
21 MR. DODSON: Well, in my experience, most
22 states have a number of different options available for
23 that, whether you have a purchasing coalition of like
24 type industries, a state option, you're big enough to
25 self-insure and re-insure and you can go out and find an

1 administrative services firm or one of the entities like
2 PHCS or Beech Street that will get you a network.
3 So, you don't have to be particularly large.
4 MS. DARLING: Five hundred is the usual number,
5 500 employees.
6 MR. DODSON: Yeah. And if you can find a few
7 of your friends and put together something to go approach
8 in terms of some type of buying coalition, you know, you
9 can structure it that way. There's actually a great deal
10 of flexibility out there if you are willing to take a
11 look at it and that's where people work with brokers and
12 consultants towards that type of solution.
13 MS. DARLING: This is also where -- a lot
14 depends on what you want to give your employees. I mean,
15 if you look at the data, it's the large employers who
16 actually have the richest benefits and the most
17 comprehensive plans many times. There are lots of
18 employers, the smaller ones, that do provide a health
19 insurance product and you may pay all the difference
20 between what's reimbursed and what the doctor charges.
21 We still have people in those kinds of plans. I mean,
22 we've all gotten caught up because we talk about HMOs,
23 but the fact of the matter is there are lots of people
24 with just regular health insurance out there and more
25 will come.

1 So, a lot depends on what you, as an employer,
2 want to provide to your employees and whether or not --
3 what's the labor market. I mean, if you go back just
4 three years, we still had people wanting to be an
5 employer of choice. We've had a recession, we've had 9-
6 11, we're in terrible shape right now. So, nobody's
7 sitting around saying, I've just got to give more
8 benefits to people to keep them here because the economy
9 is completely different. So, this is also a time when
10 there's going to be much more likelihood that an employer
11 -- if they're looking at a 10 or 15 percent increase,
12 they may say, well, you know, I may take either -- not
13 even a PPO, maybe I'll go back to an old fee-for-service
14 plan and just simply buy an insurance product.
15 It's just so different today than even two or
16 there years ago.
17 MR. GABEL: From our national survey we find
18 firms with as few as 50 workers who are self-insuring.
19 Maybe they shouldn't self-insure, but they do self-
20 insure. The part of the nation where we have more self
21 insurance than any other is the South and it has been
22 that way as long as we've been doing the survey. And why
23 that is, that's difficult to figure out. Certainly,
24 mandated benefits are not the explanation because those
25 states do not tend to have high levels of mandated

1 benefits. States such as California and New York, the
2 Northeast, have less self insurance than the rest of the
3 country. In our survey, we are down to 5 percent of the
4 nation of employees now being enrolled in indemnity
5 plans.
6 MR. DODSON: Oh, I can actually give you a
7 personal example of taking it down to five people. You
8 know, my option was, to buy with a small consulting group
9 a plan offered by one of the insurers. I looked at it
10 and said, I don't like that premium price. It created
11 for everybody MSAs with catastrophic coverage and it was
12 substantially cheaper and a wiser business decision than
13 buying insurance. It's a very viable alternative for
14 small entities if they wish to go down that path. So,
15 you can take it down to fairly small levels if you
16 understand the industry and know what your choices are.
17 MS. DARLING: If I just may build on that
18 because I was just in some conversations with a group of
19 people who are selling large corporation health
20 insurance, and one of the things they're seeing is you
21 could -- I'm sure the terminology is something like a
22 hollowing out of the benefit, that basically if you're
23 sitting across the table and you've got 15 employees and
24 you've just had presented to you per employer $250 is
25 what it is roughly, and somebody's just come in and said,

1 all right, it's going to go up another 20 percent and you
2 say, okay, what can I do. And this conversation is
3 happening every day in this country. And they'll say,
4 well, you know, you can cap this, you can do that, you've
5 got all these options, and basically you do as much
6 taking away of the extra, more costly benefits and of
7 going back to more co-insurance, cost sharing, caps on
8 things, not covering limits and say number of visits,
9 things like that, to bring that number down to something
10 that's closer to keeping it at $250.
11 And I think we'll see that all over the
12 country. And that will, in turn, affect all that we're
13 talking about here because you're going to have a lot
14 more people walking around as real consumers. Now, you
15 could argue that's bad, you could argue that's good, but
16 that's what's going to happen.
17 MS. LEE: Lawrence, I want to follow up on
18 something you had said before. You have said several
19 times that you believe entry is pretty easy in this
20 industry and you presented one graphic which showed
21 changing market shares, I believe, in Atlantic City, New
22 Jersey from '94 to '98. And then you made reference to a
23 study you had done of a greater number of markets. I've
24 actually seen this larger study.
25 One criticism that I have had about this study

1 is that in a lot of these markets, you see growing total
2 enrollment, and so, in this environment, even though
3 market shares may be changing, it doesn't mean that the
4 new entrants are actually taking customers away from the
5 incumbents. So, market shares may not be so informative
6 about the competitive state or the competitive
7 positioning of the health insurance companies or HMOs.
8 So, in addition to your own criticisms, I'd
9 like you to address this. And then I'd throw out a more
10 open question to the other economists and everyone else.
11 Certainly, we all know the problems with market shares
12 and Herfindahls, but often, it's the best we can do. And
13 are there other things that we should be looking at in
14 order to evaluate the competitiveness of markets.
15 MR. WU: Well, I guess I have two general
16 responses. One is, in some of these markets, you know,
17 there has been an increase in market size, meaning total
18 enrollment has increased in the marketplace. But still,
19 whether you are a new entrant or an incumbent health
20 plan, there still is competition for that new business.
21 So, even if it were the case that the leading firm in the
22 marketplace basically lost share because it stood still
23 and did not increase its enrollment and let new entrants
24 just carve out a place in the marketplace, one, that
25 seems to me unlikely; and second, my sense still is that

1 there is still a lot of competition for that new
2 business. That business had to come from somewhere. So,
3 I'm not sure that it's really the case, that the new
4 entrants got to be 47 percent of the market just because
5 it's brand new business. So, if the numbers are small,
6 that might be a more valid criticism, but these entrants
7 really do have -- received 47 percent share.
8 Now, I guess my other point is that, again,
9 when you look at shares, it does hide a lot of churn
10 that's underneath all that. And, again, that goes to all
11 these studies that show that consumers are willing to
12 switch on a dime. And it's that kind of churn that you
13 don't see with market share numbers.
14 MS. LEE: Steve.
15 MR. PIZER: Let me just comment. I'm not going
16 to disagree with some of what Lawrence is saying. I
17 think there's -- but I'd make some distinctions. There's
18 pretty intense competition -- and the markets that I know
19 the best are the Medicare markets -- for the younger and
20 healthier risks. And that's where the churning is, also.
21 So, market shares may not be moving that much, but
22 there's a lot of competition for the younger folks. And,
23 in particular, in the Medicare markets, there's the
24 supply of younger folks coming in. So, a plan that isn't
25 being successful competing for younger risks, even though

1 those are just sort of the marginal new enrollees, is
2 going to have trouble over a period of a few years. So,
3 that's where I don't disagree.
4 Related to your question about problems with
5 market shares and -- I think the measurement of
6 elasticity of demand is very interesting. I do kind of
7 disagree with the generalization that Lawrence has put
8 out there about people switching on a dime. I've read a
9 number of papers now that estimate the elasticity of plan
10 choice with respect to premiums as being kind of
11 surprisingly low. Now, it depends on what you're looking
12 at, what products you're looking at. But particularly as
13 people get older, they just don't switch that much.
14 So, this kind of gets back to what I was saying
15 earlier. If you're concerned about these issues, there
16 are corners of the market where the concerns are more
17 justified. Older people is one of the areas where you
18 really have to worry about the stuff more.
19 MS. LEE: Fred?
20 MR. DODSON: Actually, if you look at it, if
21 I'm a health plan, I'd probably go into the market for
22 two reasons. One, I believe that there's an unmet need
23 that I can meet and that will, over time, pull
24 competitors to meet that need if they haven't previously.
25 Second, I believe I can go into that market and compete

1 and take membership away from competitors because I
2 provided a service or quality or price advantage they
3 don't. Absent those two, you know, you don't logically
4 go into a market. And both those interventions into the
5 market are healthy things for a market.
6 MR. WU: Maybe this is a comment and maybe Mike
7 Mazzeo can follow up. But if I interpret his work
8 correctly, his finding would suggest that the second firm
9 or the -- say you had one firm in the market. The second
10 firm that would enter would come in a little bit
11 different so as to not compete directly, and I think that
12 goes to, Fred, your point about unmet need. But by the
13 time you hit that second entrant, pretty soon you do have
14 that competition because those entry threshold ratios,
15 you know, get pretty close to one and by four, it's --
16 you know, you're right in line with those tire
17 manufacturers.
18 MS. LEE: And the doctors.
19 MR. WU: And the doctors and the dentists.
20 MR. MAZZEO: Can I respond to a couple of
21 things?
22 MS. LEE: Sure.
23 MR. MAZZEO: First of all, I guess I'm quite a
24 bit more in touch with the statistics about the use of
25 demand elasticities in this context and it's mainly for

1 the reasons that were brought up earlier about individual
2 negotiations between employers and health plans. I think
3 that if you're going to have any hope to do a really
4 careful demand elasticity study that would be useful
5 policy precedent, you'd have to have a good stable set of
6 prices and product characteristics.
7 As was discussed earlier, if prices are going
8 to go up, then employers have the opportunity to
9 negotiate with providers to change the characteristics in
10 the product such that maybe prices don't change, but the
11 plans that are offered are going to be different. So,
12 it's very -- you know, I think it would be very difficult
13 in practice to calculate the effect of a change in price
14 that held plan characteristics constant in any meaningful
15 way, which is what you would need in order to do a demand
16 elasticity kind of study accurately.
17 So, you know, for the reasons that were
18 discussed earlier, even the HHI and the concentration
19 ratios have difficulty because that's why in our study we
20 fell back to just this basic idea of firm count and
21 trying to incorporate some of the differentiation to that
22 as well, but when it comes right down to it, the number
23 of possible choices that firms have -- that employers
24 have is going to ultimately determine the negotiating
25 power.

1 Now, having said that, I think that there is
2 potentially an opportunity to incorporate auction theory
3 into the analysis of merger and other kind of policy
4 analysis for the reasons described earlier, that
5 essentially, firms are bidding against each other for
6 employers' business and if we think of the competition
7 like that, there may be potentially some new economic
8 theory that we can bring into the policy evaluation.
9 MS. DARLING: Just two points I'd like to make
10 that tie back to several of the comments. One, I believe
11 that if an individual does not have to change his or her
12 physician, they will move on very small dollars. So, you
13 have to disentangle that. It is true that if they have
14 to change physicians and that they have to sort of start
15 over, the combination of inertia and other things come
16 into play at all age groups. Inertia probably affects
17 the younger more than any. So, that's one point.
18 The second is, as I'm listening to the
19 discussion about the competition and everything, the
20 geography is really important because I think about, as
21 this discussion was going on, California. If you go back
22 about 10 years or so, you had the Kaiser Permanente.
23 They were not growing. In fact, they were probably
24 shrinking and one of the reasons they were shrinking is
25 because they were tied to certain relatively

1 circumscribed geographies and had chosen not to go beyond
2 that, and the sort of younger, hipper, more
3 entrepreneurial, et cetera, et cetera, companies were
4 coming in and not just maybe picking up a little market
5 share in the areas that Kaiser dominated, but also going
6 to the suburbs and they were following the population.
7 If you look at the Washington, D.C. area, for
8 those of you who know this, this is another good example.
9 If you have employees in Washington all over Montgomery,
10 Arlington Counties, et cetera, then you're going to have
11 to offer one or two plans that have doctors in places
12 like Germantown and even further than that or even West
13 Virginia. So, you know, those are different competitive
14 opportunities and what you would put in and where the
15 growth is going to be is partly a function in high-growth
16 areas, like Fort Worth, Texas and Washington, D.C. and
17 other markets, especially where they're spread out.
18 You will have plans that are particularly
19 strong, let's say, in upper Montgomery County, to use an
20 example, and others will be strong in Springfield. So,
21 you've got some overlap, but you also have some very
22 significant differences. So, you will have strong plans
23 and people will make different choices depending on where
24 they live.
25 MR. PIZER: Just a very quick comment. I don't

1 disagree with what you're saying at all. I think we're
2 just coming from different backgrounds. When I am
3 thinking about these issues, I'm thinking about
4 individuals who are making their own arrangements, either
5 buying Medigap plans or signing up for Medicare Plus
6 Choice plans and I think, generally, you're thinking
7 about employers --
8 MS. DARLING: Right.
9 MR. PIZER: -- getting plans for -- and
10 multiple plans which employees will choose and those are
11 just totally different marketplaces.
12 MS. DARLING: Right, right.
13 MR. PIZER: The other marketplace that we
14 haven't talked about at all is non-group or individually
15 purchased insurance. And I'm not aware of any literature
16 on premium elasticities there. What Mike said is
17 certainly true about the shortcomings of doing premium
18 elasticity work when you can't see what the prices are.
19 And, again, you know, my head is just in a different
20 place.
21 But individually purchased markets are much
22 thinner and would be another sort of corner of the
23 marketplace that might merit some attention.
24 MS. DARLING: There's probably a lot more
25 turnover, too, because you see a lot of people going on

1 and off individual policies because that's -- you know,
2 they come off COBRA and then they have maybe six months
3 before they get another job or something and so you see a
4 lot of turnover there.

5 MR. GABEL: When we were discussing employee
6 choice, I think we just need to remind ourselves that not
7 all employees in the country do have a choice of health
8 plans. My statistics are higher than everybody else's
9 statistics. If I were to go with Steve Long's
10 statistics, it would be only about one-third of the
11 employees in the country have some kind of choice.

12 MR. HYMAN: I wanted to change subjects a
13 little bit and ask about state regulation and its impact
14 on the discussion. Fred mentioned the network advocacy
15 requirements strengthening the hand of the providers in
16 the negotiations and mandated benefits have come in for
17 some abuse as well, and not just here.

18 I guess the question that I had, though, was it
19 seems to me it might have another effect that could start
20 operating, which is, depending on how the mandates are
21 structured, if you even specify an entire benefit
22 package, you change the nature of the competition and, in
23 particular, on Mike's results, what differentiates the
24 national firms from the local firms is that they're
25 offering different benefit packages rather than going to

1 different providers in the same market, whether that
2 might change the dynamics so national firm entry would
3 enhance competition with local firms rather than only
4 against other national firms?
5 MS. DARLING: But national firms have thousands
6 of benefit packages. So, they have so much -- you know,
7 they're basically almost like a continuum of options and
8 there's never -- I mean, once in a while, you'll stumble
9 on a company that will have a very limited repertoire,
10 but the repertoire is becoming more extensive, not less
11 extensive.
12 MR. HYMAN: Although, I mean, if that's a
13 complete description of what's going on, it's hard to
14 explain Mike's results because then each new national
15 firm entrant shouldn't compete with each prior one,
16 whereas his results indicated -- I'm actually not sure
17 you were here for that presentation.
18 MS. DARLING: No, I wasn't.
19 MR. HYMAN: Okay, well, then I won't tax you
20 with his results.
21 MS. DARLING: I wouldn't want to let data get
22 in the way of my opinion.
23 MR. HYMAN: Just more generally, I guess the
24 question is, how do you see state regulation as playing
25 out in this context? Is it market-enhancing? Is it

1 market-replacing? Is it just bad news all around?
2 MS. DARLING: Well, our view is it is certainly
3 not market-enhancing. It is very harmful to the markets
4 working in a couple of ways. First of all, the state
5 regulation almost always tends to be something that ties
6 people's hands and because it is always driven by narrow
7 special interests wanting not just -- well, give me eye
8 care instead of something else. It's give me everything
9 you're giving me and give me eye care. Give me this.
10 So, it is always accretive to whatever's happening
11 because every time something new comes in as a mandate,
12 every other narrow special interest that hasn't had their
13 mandate has to come in. So, it is really dysfunctional.
14 That's number one.
15 Second, you know, in a way, some of the
16 companies -- in a way, mandates essentially also get them
17 off the hook for competing and using wisdom in selecting
18 benefits and managing. So, it's not just sort of
19 blatantly dysfunctional in our minds, it also makes it
20 impossible for health plans and insurance companies and
21 anybody in that business to compete on combining and re-
22 combining the best packages to serve -- you know, with as
23 much diversity as possible.
24 So, I mean -- and the other thing is that they
25 are almost always not thoughtful in the way they come

1 through. That is, for example, it will always be a lot
2 of something as opposed to -- usually because it's a
3 political process, not a scientific process. They don't
4 look at the scientific evidence about whether something
5 is effective before they mandate it. They mandate a lot
6 of things that are not only not effective, they're
7 certainly not cost effective.
8 So, there's -- anyway, you can tell, sorry, I
9 feel deeply.
10 MR. HYMAN: Tell us what you really think,
11 Helen.
12 MR. MAZZEO: June, can I answer this question
13 also?
14 MS. LEE: Sure.
15 MR. MAZZEO: I think it's a pretty interesting
16 idea the fact that maybe state regulations could, in
17 fact, make markets more competitive because by mandating
18 a certain set of characteristics that HMOs would need to
19 include that makes the individual competitors more alike.
20 And so, you might imagine that if what these firms were
21 competing on was a list of things that they offered to
22 the employees, then a state regulation that mandated a
23 greater list of things would reduce the potential for
24 product differentiation and then, in turn, promote
25 additional competition among firms that did exist in the

1 market. So, I think that's a potentially interesting
2 idea. We did not look at that issue in our study, but we
3 did find that national firms were less likely to enter
4 into states where there were more state regulations,
5 whereas that effect did not seem to matter as much for
6 the local firms. You know, potentially, they were
7 lobbying their local state regulators to mandate services
8 that they were already providing that would be more
9 costly for national competitors to provide.
10 MR. GABEL: Well, I think it's noteworthy that
11 Alain Enthovin always advocated standardized benefits
12 packages. Standardized benefits packages promote price
13 competition. That doesn't mean it makes it better, that
14 that's a better policy choice, standardized benefit
15 packages, but I think it does promote price competition.
16 I also want to note that, I think, Helen,
17 there's good mandated benefits and there's bad mandated
18 benefits, and let me give an example. Most of them are
19 bad, but let me give you a good one. A good one would be
20 mental health benefits because what we know from history
21 is if we do not -- if we do not require all employers to
22 offer -- well, let's back up.
23 If we look at the mental health market, you
24 will notice that it does exactly what insurance isn't
25 supposed to do. It does not protect you against

1 catastrophic cost. People have done all kinds of caps on
2 it so they cannot cover those costs. Without mandated
3 benefits, many firms would purposefully not offer those
4 benefits so that they do not have those high cost
5 employees. There would be an erosion of those mental
6 health benefits.
7 So, in the case of mental health benefits and
8 maybe certain other benefits, I think they probably are
9 good, I think they probably promote price competition
10 rather than by preventing competition to hire healthy
11 employees.
12 MR. WU: My reaction really is a follow-up to
13 Helen's reaction, which is unless we think that
14 competition will lead to benefit packages that are sub-
15 optimal or extremely poor, it seems to me that we're
16 almost always better off having firms compete on as many
17 dimensions as possible as opposed to constraining
18 competition to being limited to price or only a few
19 dimensions. So, that would be my comment.
20 MS. DARLING: And could I just build on that
21 and tie it back, there is a difference, in my mind,
22 between mandated and standardized. We actually have
23 standardization driven by the labor market and -- I mean,
24 it's interesting because what Lawrence said is correct
25 and what's happened is that almost all companies provide

1 very similar sort of benefits. Maybe there's a little
2 bit of difference on mental health, but if you look at
3 the -- I mean, I used to do this for a living.
4 If you look at benefit packages, there's sort
5 of the average that you expect to have. You could almost
6 predict, you know, it's X number of chiropractic visits,
7 it's prophylaxis of this and, you know, scaling of teeth
8 and all this stuff, they're all very standardized, but
9 they do compete on certain things and I don't think that
10 -- mental health, by itself, is not what they compete on.
11 That's a whole other subject.
12 We should have a session on this. I would take
13 issue with most of what Jon said, I'll just say that for
14 the record. Love to have the chance. But to get back to
15 the point, I think we do actually and it's particularly
16 true, if you will, in a good job market that, in fact, if
17 anything, some of us in the business, I've jokingly said,
18 because of the job market, essentially corporations gave
19 away far more health benefits than they should be doing
20 for purposes of having an informed consumer and things
21 like that, but we shouldn't have made it so easy. And
22 now, we're having to undo some of that.
23 But it became very standard, I mean, almost to
24 the penny what you would get if you went to work in
25 almost any of the regular places, you know, government

1 jobs, think-tank jobs, large corporations. Very
2 standardized.
3 MR. HYMAN: As a professor, it's a thrill that
4 people want to go past the allotted time, let alone
5 suggest an additional class as Helen has. I must say, in
6 10 years of teaching, neither of those things have ever
7 happened to me. It's clearly June's beneficial effect.
8 But it's 5:00 and we need to wrap up and we're going to
9 pick up tomorrow morning at 9:15 and we've heard about a
10 number of different songwriters, so we'll close with
11 Fleetwood Mac, don't stop thinking about tomorrow.
12 **(Whereupon, at 5:00 p.m., the hearing was**
13 **adjourned.)**
14

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 MATTER NUMBER: P022106

4 CASE TITLE: HEALTH CARE AND COMPETITION LAW

5 DATE: APRIL 23, 2003

6

7 I HEREBY CERTIFY that the transcript contained

8 herein is a full and accurate transcript of the notes

9 taken by me at the hearing on the above cause before the

10 FEDERAL TRADE COMMISSION to the best of my knowledge and

11 belief.

12

13 DATED: MAY 12, 2003

14

15 ________________________________

16 SONIA GONZALEZ

17

18 **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**

19

20 I HEREBY CERTIFY that I proofread the transcript for

21 accuracy in spelling, hyphenation, punctuation and

22 format.

23

24 ________________________________

25 ELIZABETH M. FARRELL