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ANTITRUST DIVISION

PRESENT:

HEARINGS ON

HEALTH CARE AND

COMPETITION LAW AND POLICY

WEDNESDAY, APRIL 9, 2003

FEDERAL TRADE COMMISSION

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P R O C E E D I N G S

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MR. HYMAN: Good afternoon. We're going to get started with our mid-April set of hearings on Health Care and Competition Law and Policy. These hearings are jointly sponsored by the Federal Trade Commission and the Department of Justice, and sitting next to me is Scott Thomson from the Department of Justice Antitrust Division. We're going to be co-moderating this afternoon's panel.

Today we're going to talk about hospitals and specifically horizontal networks and vertical arrangements, and we're lucky enough to have four speakers, two of whom are talking about horizontal arrangements and two of whom are talking about vertical arrangements. So, the symmetry will hopefully work out well.

The four speakers for today, consistent with our general framework of abbreviated introductions so everybody can talk longer, are to my far left, Bob Hurley from Virginia Commonwealth University, who is speaking on behalf of the Center for Studying Health System Change. Sitting next to him, Jim Burgess from the Boston University School of Public Health. Seated to my right is Bob Town, from the University of

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Minnesota. Is that public health or economics?

MR. TOWN: Public health.

MR. HYMAN: And then the empty chair to his right, which will soon be occupied by Robert Burns, who is at the Wharton School of Business at the University of Pennsylvania. And our plan this afternoon is to have each of the speakers speak for about 25 minutes or so, then we'll do all four, take a short break, and then continue with a moderated discussion, wrapping up no later than 5:00.

Let me just give a brief preview of the balance of the week. Tomorrow morning, starting at 9:15, we're going to cover hospitals, specifically nonprofit status issues. In the afternoon we're going to do joint ventures and joint operating agreements. And then on Friday morning, following some brief opening remarks by Commissioner Sheila Anthony, we're going to spend several hours looking in detail at the Little Rock market. This is a session that was originally scheduled February the 28th, but was postponed due to inclement weather. I hasten to add the inclement weather was in Little Rock, not in Washington, D.C.

And Friday afternoon, starting at 1:30 and going until 5:00, we will cover post-merger conduct, and we have excellent panels for each of those. There will be

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a call-in for each of those days as well, and following our wrap of that session on April the 11th, we will reconvene about two weeks later to start working on insurance and insurance companies and we'll have sessions continuing through April, May, and June. And our expectation is that we will complete all of these hearings by September, assuming all goes well. Perhaps, I'm careful to say September at the moment.

So, with that, let me turn it over and I think showing my lack of imagination, I am going to go left to right in order, so, Bob, if you could start off, we would appreciate that.

Let me just add one other remark for the people who are listening, which is that the PowerPoint presentations that are being shown should be posted on our website within about a week and transcripts of this session should be posted within about a month. It takes that long to turn them around. If you look at the hearing's websites, which there is an FTC one, as well as a Department of Justice one, you will find a broad range of materials that weigh into the hearings, past sessions, PowerPoints, transcripts and so on.

Thank you.

MR. HURLEY: Thanks, my pleasure to be with you today, and I actually am going to talk about vertical

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and horizontal both, so I'm not sure who the other person is who is splitting the topics with me. I'm going to talk about the vertical and horizontal integrations in the community tracking studies in these markets. I'm sure some markets you've probably heard about, and some of my colleagues have presented to you previously, in terms of these markets around the country that we study very closely and carefully on a biannual basis, and when we see the map when it comes up, you will actually see where these markets are.

What I will be talking about briefly is provider integration that is observed in these markets, horizontal and vertical integration illustrations of what we see, and then I want to focus in on a couple of very specific illustrations of this hospital health plan sponsorship and then some of the evolving developments in hospital/physician relationships. And then draw just a few conclusions at the end. So, that's the kind of preview or the road map for what I'll be doing.

The Center for Studying Health System Change, if there's anyone in the world who doesn't yet know who we are, because we do a lot of these presentations, is a center founded in the mid-1990s fully funded by the Robert Wood Johnson Foundation. Our goal is to do objective, independent research on how private markets

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are changing across the country, how these changes affect people, consumers, and what the implications are for policy makers. And you can see our website here.

The community tracking study, as you're probably aware, there are actually two components to the Health System Change work. We do surveys in 60 markets across the country, and in 12 markets, the community tracking studies are markets in which we do in-depth biannual site visits to these markets. We have been following them since 1996 and we are in the process of completing our 12 markets for the fourth round here right now.

The markets are selected as a representative sample, you'll see that in a moment. They speak to national trends, I think reasonably well. There's some geographic maldistribution, perhaps, but they are stratified into kind of mega markets, large markets and then smaller metropolitan areas. And they ostensibly represent the average health care markets.

In the course of these site visits, we will do 70 to 100 interviews in each of the sites on this two-year cycle. We do a broad cross-section of interviews with health care executives and stakeholders. We say we triangulate the results, we actually quadrangulate them because we really interview in four sectors, we interview on the health plan side, and the

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provider side, and the purchaser community and then the policy makers with respect to state and local governments in these communities.

These are the sites, and I'll be drawing a lot of my examples, of course, from the identified sites in this -- on this map. The white marks on here represent the 48 other markets in which we do surveys, the physician and consumer, household and purchaser surveys, and then the 12 markets that are listed are the ones that we've been -- we are in the process of visiting them. We just went to Phoenix, Arizona, last week, and I think some of my colleagues are in Miami this week and Boston in a couple of more weeks and that will complete the fourth round of visits in these markets.

So, what have we seen as far as the evidence of vertical integration and horizontal integration in the community tracking sites? Well, let me just sort of give you some big bullet items and then we will drill down through these. Integration is quite extensive, as you'll see, in these markets. It's been undertaken for multiple purposes through various forms of arrangements. We've been doing these market visits since 1996, so we have actually seen a bit of a cyclical pattern with respect to this integration activity, and I'll try to dwell on that a little bit.

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Horizontal integration has increased and then it has slowed over the course of our site visits, largely because of the consolidation that's occurred in the market. We are sort of reaching the limiting point in a number of our markets where consolidation is simply maxed out.

Vertical integration itself has had an interesting life cycle to it as well. Vertical integration activities were much more apparent in the earlier rounds of our visits, they have slowed, and in some instances have reversed, and we'll describe some of the rationale for this and the reasons for this as we've observed them in the market.

Today the vertical integration activities that we're observing are much more targeted in their strategic age. The earlier ones one could say were almost mimetic, they were imitative of other people sort of taking the responsibility to make changes as observed in other markets that are much more selective and purposeful today.

And I think a central point of my entire remarks will be the changing market conditions have influenced the value of integration, both for these health systems that are engaged in it and also the markets in which it's occurring.

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Just a picture to kind of give you a sense of how we'll be presenting this, the horizontal obviously of the flagship hospital with its affiliated hospitals is the most common form we observe in our markets. And we have some markets, such as Orange County, California, where we have a single health system that owns ten hospitals. That happens to be the Tenet system. In other markets, these are more smaller scale of horizontal integration.

And then the vertical integration represents a wide range of activities, of related activities that have been undertaken by this same focal institution or typically the focal institution, many of which are going to be characterized as ownership kinds of activities, the dotted line with respect to these affiliated physician networks is something I want to dwell on because I think we have seen a transition, a transformation really in the nature of the physician/hospital relationships that is emerging in a number of markets, and moved away from the spell of time in the mid-nineties when practices were being purchased extensively by hospitals.

Provider horizontal integration, again, several markets in which this is evidenced, I only highlight the Cleveland, Phoenix and Orange County because this is

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where it's very evident and very widespread in terms of a several multihospital system is evident in these markets.

With respect to the aims, why are the institutions in these, why are they undertaking this as based on what they're telling us and what other observers in the community have told us. They're enumerated here in several points, again, which will resonate with your general understanding of the rationale and motivation for horizontal integration.

Improved operating efficiency is certainly a frequently espoused and touted rationale for engaging in these, achieving degrees of economies of scale associated with operating multiple facilities in a single market.

Minimizing duplication and redundancy is also one of the rationales that's been advanced, I'll give you a little bit of a different take on that in terms of the yields from these, but the idea that by having a single system with strategic purposes there would be a possibility of creating more -- sorting out, if you will, of the citing of care and the citing of services.

Clearly to reduce the number of competitors is a motivation in terms of encouraging and engaging in horizontal integration and several of the institutions

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have acknowledged that.

Aligning and achieving strategic purposes among units, again, this is the idea of actually operating as a system in a market as opposed to individual atomistic facilities.

Promoting channelling to the flagship, of actually being able to route referrals in a more systematic and reliable basis to the facilities with the most intensive capabilities or most extensive services.

Expanding geographic coverage is a very important consideration. Several of our markets which are widespread and dispersed, we were just in Phoenix last week and, again, Phoenix is a market that is growing in terms of population, roughly 150,000 people a year come to Phoenix, but because of the geography there, the dispersion of the population is such that most of the hospital systems or hospitals in that community have now developed suburban locations are further and further out from the core of the city in order to accommodate and respond to that growth and also to capture the referrals from those locations.

And certainly this last issue, improving and negotiating leverage with payers is a primary negotiation. Partly acknowledged by the provider systems, certainly recognized and discussed by the

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health plans and insurance companies here doing business in these markets.

With respect to some of the yields from this horizontal integration, let me just highlight a few of these that are evident from our interviews. And again, reflecting the fact that our qualitative information has limitations in terms of just how much depth we can go into in terms of drilling down and testing these assertions.

What we've seen is a significant amount of service expansion in affiliated hospitals. I draw that contrast against what I suggested earlier, that the idea of one of the rationales for pursuing vertical integration was to minimize redundancy and duplication. What we've found is that many of the facilities that have affiliated with a horizontally integrated system have availed themselves of the opportunity from this affiliation to expand their service capabilities, to bolster what were weak institutions in the past and this actually has probably worked against the idea of actually reducing redundancy in the market.

Clearly we've seen improvements in hierarchical flows of patients among the affiliates. This is sort of flowing patients into the flagships in a way that gives the flagship, the lead hospital in the system, more

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certainty with respect to the high end kinds of services.

There are fewer independent facilities in the markets, and I would like to go to the next point as well, the markedly enhanced negotiating leverage with the plans has, in fact, contributed to that, if you will, the idea of fewer independent facilities, given the negotiating positions that horizontally integrated systems enjoy, it is difficult for independent facilities to be able to garner the same kinds of contractual terms and opportunities that the system-affiliated institutions can, unless they have a particular market niche of some kind or geographic advantage.

So, what we have seen is kind of a snowballing effect of independent facilities joining these markets, and having been back to these markets now on four different occasions, we can see that kind of centripetal force, I guess, pulling in rather than spinning out amongst these institutions.

The potential to pursue exclusive affiliations with selected plans is also enhanced through this horizontal integration, particularly for those facilities that have been able to achieve broad market coverage, geographic coverage. They are now able to

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present, for those health plans who are interested in exclusive affiliations, are able to present a health system that with a single signature can actually be delivered -- a hospital system that can deliver facilities across an entire market. And again, that's an aim for some of these systems to achieve that level of market scope.

And the last point I make is the one I just qualified by suggesting that our level of detail in terms of our understanding and the source of our information is unable to assess the impact on operational efficiency. Again, we're dealing with some assertions in this case in terms of the ability of organizations to contend that they are able to achieve certain economies of scale. On the other hand, we're not in a position to be able to validate that.

Now, let's shift to the vertical integration, if we could, for a moment, in terms of looking at the kinds of activities that are under way. Some of the aims that are under way. Again, we see this virtually in all of our markets, although I suggested at the beginning, somewhat less so than what was evident when we went to the markets in our first rounds back in the mid-1990s.

Greenville, Indianapolis, Lansing, Orange County, Cleveland, again, Cleveland and Orange County

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are the ones that have the vertical and horizontal activities.

With respect to the aims of vertical integration, we've seen and heard extensive interest in pursuing these for the purpose of controlling patient flow, locking in market share. Whether it's affiliations with individual practitioners or acquisition of practices, as we saw five or six or seven years ago, or whether it's just alliances and structural arrangements that create a kind of forced loyalty, we've seen those kinds of activities and the yield from those, I think, has been significant in a number of instances.

We've also seen this ability to solidify relationships, to move beyond just the tacit understanding of referrals to owning practices and requiring the referrals to be made to selected facilities. Again, that's a purposeful yield from these efforts.

Certainly, again and again in some respects, this almost seems like ancient history today as we think about over six and seven years ago. As we saw the ascendancy of capitation, the expectation that capitation becoming the predominant form, the prevailing form of payment, the position to receive and to distribute capitation dollars was a powerful motivator

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in the mid-1990s for these delivery systems to pursue vertical arrangements that would essentially allow them to control those premium flows into essentially -- make allocation decisions of those dollars.

Related to that, and of course if you think of capitation as being the physiology of these organizational entities, putting them together was kind of the anatomy, if you will, of these integrated systems. Pursuing seamlessness across the continuum of care, then became very important to be able to distribute those dollars and to distribute that care at the most efficient and effective site.

We've also seen the opportunity of using vertical integration to offer alternative distribution and contracting options, and I'll come back to that in a moment, because we've seen a number of health plans or we saw a number of health plans sponsored by health care systems as a way of generating additional competition to some of the traditional insurance companies.

And finally, although this is a diversification argument, it also is a means by which a vertical integration was a way to generate revenue flows from other sources and other types of payers, rather than just the conventional payers for inpatient and outpatient care.

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A few comments about the yields from vertical integration. What we've seen is that clearly the positioning associated with building vertical systems does expand control over premium dollar flows. It does allow an organization to have influence on where those dollars that are going for outpatient care, as well as for inpatient care, are going. Whether those dollars are going for physician care versus hospital care are going in terms of being able to create a system.

Vertical integration has clearly yielded better contract terms with managed care plans, again, in terms of whether it's getting higher payment rates, more favorable terms in terms of duration of contracts, prohibition and exclusions of certain kinds of undesirable kinds of payment methods, such as for outpatient care and so forth, the ability to mobilize that leverage as a result of having a system of care in place has been -- has yielded significant gains for systems that can pull that off.

We have also seen a number of hospital systems develop managed care products, and another slide or two down the way I'm going to show you that we actually have seen that peak -- certainly we all in this room know that this has peaked out some time ago, but we still find in a number of our markets, we do have hospital-

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sponsored plans, at least in three or four of our 12 markets, there are still hospital-sponsored health plans that are playing a distinct role in those markets, and actually expanding the availability of product offerings above what would be available just from the insurance companies and the health plans.

Physician affiliations have been enhanced, although they've gone through a very tumultuous time over the years, and I will come back to that in a moment, too. We've seen success in decentralizing delivery sites of being able to follow the populations in community with ambulatory care, surgery centers and imaging centers as a vehicle that the hospitals can maintain these relationships and can maintain these relationships with their customers in locations closer to where the customers are moving.

And finally the continuum of care to the extent that the systems have been able to put this in place and keep it in place, a challenging issue, particularly in the wake of the BBA of '97, the extent to which it's been kept in place does, in fact, improve the patient flow across the integrated systems.

But we have, as I was alluding to a moment ago, seen diminished enthusiasm for vertical integration in virtually every one of our markets over the last two

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rounds, really. We saw more of this in 2000, it's continued into 2002.

We've seen systems struggle with the ability to achieve the expected returns from their vertical integration efforts. We've seen and heard systems admit their lack of proficiency in the diversification efforts, of discovering that the advantage in other lines of business were more challenging and were different enough from their hospital management in which they're not so sure of success.

Obviously we've seen conflicting goals in competing businesses. This, of course, is the classic problem of the health -- the hospitals owning health plans, and we'll hear a little bit more about this in another slide, but this, in fact, has been a very challenging issue, and those of you who are veterans of the health care industry know we've been through essentially two waves of this. In fact it used to be called Humana 101 at the beginning of the nineties, and some people suggested that we went through the Humana 102 in the late nineties when hospitals began their own health plans and subsequently have sold those off.

We've seen a decline, a substantial decline, in capitation payments, and so the loss of those capitation payments or the failure of capitation payments to

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mobilize or to be sustained has undermined one of the important rationales for building vertical systems. So, many systems that have been dismantled were dismantled because the capitation dollars never came, or if they came, they came in such a small fraction of the overall revenue picture that they didn't really change the philosophy.

We've also seen increased demands of the core business. Running a hospital, of course, is much more challenging today than it has been in the past, because of various pressures. Financial pressures, in particular, that the hospitals are under and the ability to devote their resources to sustaining their core business as deflected from their ability to engage in other activities.

Probably the most prominent change has been in the payer environment, this came out of the balanced budget act of 1997. We did a site visit from MedPAC in 1999 or 2000. We visited a high profile integrated system in the southeast and the CEO proceeded to tell us how in the last 18 months he had sold off all the physician practices he had bought, he had discontinued his HMO that he had started, he had spun off the nursing home that he had developed. And he was in the process of shutting down the home health agency that he had

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developed, and then he said that when we're finished doing all of those things, we're going to go out and find the consultants who told us to do this and we're going to kill them. And it was sort of reflected this kind of at the end of this whole process, the environment had changed fundamentally in terms of the payer environment in terms of the suitability for doing vertical integration.

And a last point, an evident point again somewhat related to the effects of the BBA was the reduced resources for investment in these other enterprises.

So, a couple of areas where we still see activity I would like to kind of highlight for you and we've seen a significant change in terms of vertical activities related to hospital-sponsored plans and then we'll talk about the hospital and physician relationships.

Interestingly, these health plans actually peaked some time ago now. These products rarely achieved substantial scale. They were generally unprofitable for the hospitals, although it's difficult to render a very definitive judgment because typically the hospital was contracting with itself, if you will, for the substantial portion of the hospital care in the

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networks that they were creating, so it was all difficult to assess from a single site how profitable the hospital sponsored HMOs may have been.

There were clear internal conflicts associated with the tensions between promoting cost minimalization in a prepaid health plan and revenue maximization in a health care delivery system. Again, this was a point on which many of these systems foundered.

They remained viable in selective markets, in Lansing, in Indianapolis, we see this in some of our other markets, actually, where there are still sponsored plans present in these markets, owned by health systems, because they are an opportunity for those health systems to present and to promote a competing health plan to a local dominant plan. In Lansing and Indianapolis, it happens to be very dominant Blue Cross plans. Anthem in Indianapolis and Blue Cross of Michigan in the state of Michigan. So, these health systems actually continue to sponsor these health plans as a vehicle for promoting competition in those instances.

Finally, in some markets where we haven't seen health plans maintain their -- health systems maintain their health plans, what we've seen is exclusive relationships between a health plan and a particular health system. Little Rock is an example of this, and

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I'm sure some of you will be discussing this somewhat tomorrow, that that really obviates the need to have a health plan sponsored by providers, if, in fact, they are moved into a kind of hand and glove relationship with the dominant health system.

The physician/hospital linkage evolution is very interesting, I think very important, and probably underappreciated at this point in terms of the longer term implications of it. We know a lot of it from what happened in the nineties, but I think we're still in the process of discovering where this is leading us.

We saw a decline in risk-based payments and that led to the abandonment of many of these formal structures, these physician/hospital organizations, PHOs that were in vogue in the mid-1990s. Surprisingly, in some of our markets we still see physician/hospital organizations in place. Even in the absence of capitation in some instances, the health systems have continued to finance or subsidize them, physicians have continued to maintain affiliations with them.

In some instances, such as Indianapolis, this is a vehicle for distributing capitation by the hospital-sponsored HMOs, the HMO that dominates that -- that's the major competitor for the Blue Cross plan.

In other cases, the health system affiliation

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with the PHO is a way of improving negotiating leverage for the physicians by essentially moving in tandem with the health system in terms of its negotiations. Health plans have significant ambivalence about dealing with these PHOs in many markets. The plans vary in their responses to them, they essentially are playing the so-called messenger model role, of carrying the offers from the health plans to the providers and the providers then maintain the opportunity to choose to participate or not.

Some health plans prefer this as a means of contracting, a kind of turnkey arrangement to be able to get a single network but dealing exclusively with the PHO in a local market. Other plans refuse to deal with them and actually have threatened legal action against them if they attempt to play too prominent a role.

It's unclear, again, from our vantage point of our sort of 500,000 foot view, it's unclear whether PHOs result in higher physician payments, but the assertion is made that they stay in place because the physicians believe that by having this affiliation, it somehow enhances their negotiation leverage.

Today what we're observing, and this is a qualification I want to put on the overall development, if you will, the more targeted purpose and purposeful

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nature of vertical integration than we're observing now. Health systems are facing significant challenges from specialty physicians. I believe that in some of your earlier hearings you've had some discussion of specialty hospitals and single specialty hospitals rising.

Vertical integration for some health systems today is an initiative that may preempt or co-op physician maneuvering. To preempt the physicians from going off and making a deal with an investor-owned or an entrepreneurial group that is going to come to town and build a facility for them or to perhaps build a facility themselves with their own capital.

We see this in markets like Syracuse and Lansing, the sponsorship of ambulatory surgery centers and imaging centers has been a controversy in which the full-service hospitals have argued this is a threat to our vitality if, in fact, this bundling is permitted to go through by those who would draw these services out of the hospital.

In other markets like Indianapolis, Phoenix and Little Rock, it's actually been a much higher level of activity, because of the growth of specialty or the boutique hospitals. Indianapolis is a city that has a number of freestanding heart hospitals under way, freestanding orthopedic hospitals. Phoenix has already

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had a number of those already built. These are markets where specialty facilities are up and running, and in some cases, representing a significant challenge to the full-service facilities.

In these cases, in these kinds of markets, you can see integration, vertical integration talk and thought and strategy is still very important in terms of how do the full-service hospitals respond to the threats represented by these. So, these activities may include building or buying or joint venturing to try to assert some hospital influence and control on these markets.

Just a word about integration and regulation. There are some elements in place in a number of states to influence the degree of integration, although they are not avowedly intending to focus on the activities of integration.

Existing state regulations, as I say here, are uneven. Horizontal integration may be subject to special scrutiny, particularly if it involves an acquisition of a facility that's going to require a conversion from not-for-profit or for-profit status.

In other states, Certificate of Need is still an active instrument, if you will, in trying to influence the shape of the market. It addresses vertical integration somewhat obliquely in terms of affecting

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capital expenditures or acquisition or even in some cases actually the divestiture of certain kinds of services.

In states that don't have Certificate of Need, hospitals, in particular, are feeling vulnerable to these entrepreneurial unbundling and dismantling activities that I was referring to earlier, and are actually trying to use the Certificate of Need vehicle as the means to try to slow that process. And clearly, payer policies have both encouraged and discouraged integration efforts in this realm.

Just to close, I would like to say that integration is a means to modify the organization's boundaries and functions in the face of a changing market environment. Over this eight-year period that we've been watching the markets, it's clear that the hospitals have had to go through some very significant contortions to try to respond to the very mixed messages in the environments that we deliver it.

Integration does enable health systems to pursue both their missions and their margins in a very clear fashion, a very purposeful fashion, but it's also true that integration activities have reduced competition in some markets and probably contributes to higher costs for consumers as a result in terms of success,

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particularly in the horizontal integration front.

Whether integration activities primarily serve institutional or community needs varies a great deal across our 12 markets, and certainly continues to be a subject to dispute. That's probably why you're talking about it today. Shall I stop there?

Thank you.

(Applause.)

MR. BURGESS: I would like to thank David and Scott for inviting me to be here today to talk about this issue. I'm also really glad that although David claimed that it was a random order that I did get to go after Bob Hurley, because Bob, I think, gave a really good overview issue around various kinds of both vertical and horizontal integration issues. And I'm going to talk in a much more micro level on one specific issue within the issue of horizontal integration, and so as a result, I think it was really helpful to have some overall background.

This is joint work with Kathleen Carrie and Gary Young, all of us from Boston University, and it's partially funded by a Robert Wood Johnson Foundation grant. Gary Young will be here tomorrow to talk in more detail about not-for-profit versus for-profit issues in some of these same areas, and this is part of an ongoing

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research agenda that the group of us have in looking at some of these issues.

I'm going to focus in, in particular, on issues of collaboration that may not be ownership-based, so that the issues, if you think about the relationships between hospitals, those hospital relationships can entail an ownership relationship, or a system relationship. Or they can also be formed in various kinds of collaborations, and these collaborations have been becoming more and more common in the health care industry.

And not actually just at the hospital level, but also at some of the other levels, at the purchaser level, at the health plan level, and also at the physician level. So, at many of the different levels these things have been happening.

Just for some context, I will try to make a couple of relationships there, and describe some of the differences about why hospital collaborative arrangements are special.

And I want to relate that, in particular, to the issue that I think, again, from an antitrust perspective, people might be interested in, which is focusing in on the hospital pricing behavior, and the history of looking at hospital pricing behavior has been

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an area that's been fraught with difficulties in trying to understand how best to try to look at a complex multiproduct market like hospital markets are.

And so, I'm going to talk a little bit about how to go into those kinds of issues. And a little bit of technical aspects, without getting, I hope, too technical.

I'm going to just outline the presentation about what I'm going to talk about today. To give you some background on the definition of what I'm calling networks in hospitals, and what the potential FTC interest might be, and DOJ interest might be, in that issue. Then I'm going to go on and talk about some of the theoretical issues and concerns, what economists have been thinking about in these areas, and what are some of the key touchstone issues that people are focusing on.

Third, I'm going to focus on a specific example. Again, Bob was sort of talking about the widely geographic approach of the health system change discussion, I'm going to focus in on one market, and that's California, that many people have been focusing in on, and I'll do that for a variety of reasons that I'll talk about.

And then, I'm going to focus in on the two sides

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to this, on how we look at hospital competition, how we look at inpatient prices, which again is only a piece of what hospitals do, and then I'll describe some further questions and issues.

First, a definition of networks. Networks, and I'm just going to use that term, that one term, are non-ownership collaborative relationships, between hospitals. They also go by a variety of names. You'll hear them called strategic alliances, joint ventures, collaboratives, and other names, associations, various other names. And I'm going to just refer to them generically as networks.

And it's important to stop here for a second and talk about some of the activities that these networks do. Sometimes the networks are formed for very, very specific things. Such as sharing capital issues, which might involve a mobile MRI machine, or something like that, that moves around between the hospitals, or even out into the community.

It might be pooling specialized resources, especially with contractual arrangements with physician groups, or specific physician specialties that might then allow those specialized resources to move around between the hospitals.

It also might be purchasing collaboratives.

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There's a lot of emphasis sort of on looking at pharmaceutical markets there, and purchasing drugs, but also in very mundane things like purchasing joint laundry services and things like that to get greater efficiencies.

And then perhaps most importantly, or especially of interest, I think, might be outpatient outreach centers, where they'll collaborate together to form and develop outpatient outreach centers in the suburbs. This is especially common with urban hospitals, who in order to compete with suburban hospitals develop outreach centers. It's a location issue, suburban hospitals may be closer located to a payer mix that's very attractive to the hospital in terms of the insurance coverage of suburban patients, and the hospital in the inner city may be overwhelmed with Medicaid patients and non-paying patients.

And the outpatient outreach centers may be an arrangement where a number of urban hospitals can get together, form an outpatient outreach center in the suburbs where patients can come in as a collection point, have outpatient visits, pre-op and post-op visits, and then try to attract them down to the hospital and compete with the hospital in that suburban area that might be the local hospital.

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So, and there are many other kinds of activities as well. Sometimes those activities are not so specifically defined, but are -- take on maybe all of these arrangements, or just pick up on opportunities that are identified by the network.

It's also important to note that this can be a precursor to ownership system relationships, where networks may be formed, and then may develop into an ownership system relationship. Or they can be a substitute for it, where hospitals are choosing a collaborative network relationship in place of more of an ownership relationship.

I also want to stop here a second and talk a little bit about some of the networking that happens at other levels. It's also true that health plans, for example, form networks of this type, between each other. And what health plans have been doing mostly is forming these networks as quality collaboratives. And they do that, actually, to, you know, bypassing hospitals, they tend to do that and focus on physicians, trying to go down and work with physicians and collaborate, and they're also now starting to go out and pay those physicians for performance and quality and outcomes and things.

So, these relationships that are non-ownership

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relationships can be very important at all levels of the health care system. Of course they're also purchasing collaboratives by the purchasing arrangements that employers get together and will make arrangements and form networks to purchase.

So, these non-ownership activities are becoming more and more important in health care. And it's important to look at them, I think, and that's why we're focusing on them today in terms of hospitals, but I think it's important to see it as a general relationship that's happening in the industry.

Let me briefly talk a little bit about some of the literature in this area, I don't have the full references here, but I've provided them to David and we certainly can make those available if you can't track it down. There has been recent focus in the literature in the area that I'm talking about focusing on profit/nonprofit comparison, which is indeed the subject of tomorrow's discussion. And I briefly list out here a number of the articles in this area.

I won't go through those, since that's really going to be a subject for tomorrow, but I do want to call attention to two things: One is that the Keeler, Melnick and Zwanziger paper also looks at the California market and looks at it covering up to 1994, and the data

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that we've been looking at and the opportunity that we've identified to look at some specific changes in these network relationships also picks up in 1994. And we use very similar methodology in trying to look at that as a way of trying to extend those results and move it forward through the rest of the nineties.

And I know Jack Zwanziger testified I think last week or the week before in some of the other hearings, so he may have talked in some detail about what he did as well.

And so, again, these studies in looking at for-profit/not-for-profit and then focusing on the question around how for-profit hospitals maybe act differently than not-for-profits in how they relate to making pricing decisions.

I also want to sort of talk about the issue of network research, and how the network research compares. Currently in the literature there's been a number of people who have tried to compare network or contractual relationships with systems, or ownership relationships. Gloria Bazzoli is probably most prominent in this area for looking at the data, and essentially the same data set that I am going to be looking at from the American Hospital Association, the detailed information on network activities in hospitals.

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And she has a number of papers, including some joint work with Steve Shortell, where they've looked at in a broad sense, looking at the performance of the -- of network and system hospitals and comparing them to each other.

In a conceptual way, the other important touchstone to the work we're doing is the Larry Casalino and Jamie Robinson work from the mid-nineties looking specifically at the California markets and comparing the environment at that time, not just at the hospital level, but also at the physician group level and health plan level, and making decisions about ownership versus contractual relationships. And some of the choices that were being made, and that's an important touchstone as well.

And then lastly, in terms of a market area calculation methodology, we're going to argue that especially if you're looking at network activities where, as I described, a lot of times the purpose of the network is to expand the scope of a hospital to move, to maybe work with other hospitals and to attract patients from outside of their traditional market areas.

It's really important to do that in a way that focuses on a more micro level look at the market. And in particular, the Zwanziger methodology from the

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Zwanziger, Melnick and Mann article is really the one that describes in detail. That methodology is a zip code-based methodology, and I'll talk more about that in a minute.

Let's sort of step back and talk a little bit about the potential FTC or DOJ interest in these network activities. First of all, of course, is that there is this session today, looking at networks and vertical arrangements and the horizontal arrangements as well. The DOJ and FTC jointly, in 2000, issued guidelines on provider collaborative arrangements, which are focused on the question around how to balance pro-consumer benefits and potential problems.

And as we think through some of the potential pro-consumer benefits, we might think about things like better information flows, efficiencies that might be to lower prices for health plans and consumers, quality improvements, economies of scale, or perhaps more likely scope economies, and also outpatient outreach centers that I just described might also give better access to a teaching hospital specialist.

Because most of these urban hospitals that are reaching out into these outpatient outreach communities are specialists that are from the teaching hospitals and may mean improved access for consumers to get to those

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resources.

On the other hand, there are also some potential problems that may arise from this activity. There's a cartelization potential perhaps if there's a focus about fixing market share or planning out market share, which I'm not really studying here at all, or perhaps in terms of making some arrangements about prices, which I will be talking about.

And in this area, there were two -- after those jointly issued guidelines, I only know about two existing enforcement actions, both took place in 2000 around the time when this was released. The -- if you wanted to go for further research on those, at least in the general popular press, Modern Health Care had articles in July 3rd of 2000 and July 17th of 2000.

The July 17th article was on the enforcement action in Florida, and the July 3rd was on breaking up a particular virtual or network system. And so those were the two that I know about. There may be others, but again, I think the -- certainly the interest today may be in trying to think about pursuing some of those issues some more.

And lastly, of course at the state level, what happens is in practical implication is when hospitals or other health care entities are looking for antitrust

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exemptions to form these kind of contractual relationships. States have generally been pretty open about giving them a lot of leeway to form these kinds of contractual relationships. And Fred Hellinger's 1998 article describes a little bit more about some of those state activities.

Now, let's step back and then talk a little bit about some of the theoretical issues, economic issues, about how we might think about these issues, these concerns. Health care is a fundamentally multiproduct good that's also produced by a complex firm or set of firms. And there's a lot of actually internal dynamics.

It's important not to think about a hospital as a unified entity. A hospital is actually a complex organization with lots of inter-incentives running through it between different kinds of specialty areas like physicians, nurses, managers, and other types of people.

And that there's a -- in economics, there are two classic theoretical frameworks that people use, which are both probably good extremes to think about, but probably not -- neither probably really describes the nature of this. One is the classic Mark Pauly physician workshop idea, where hospital placement physicians engage in activity managing it as a workshop,

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and the second being the Joe Newhouse hospital manager model which gives them more of a view as the hospital manager as coordinating resources to provide health care to patients.

And in each case I think it misses the fact that hospitals have become very complex. In fact I'm only going to be talking about the inpatient side of them, the coordination between inpatient and outpatient is in itself complex, as well as the way it interacts with other entities. So, I think keeping those ideas in mind is important.

The second thing is that the standard sort of economic theories that you might bring to bear on this tend to be developed based on single product definitions, which don't apply very well. And a number of new theories have been developed in health care to try to explain behavior across horizontal and vertical integration and arrangements activities. One of those is David Dranove's theory of option demand which says that health plans might want to set up contracts with a hospital or patients may want to contract with a health plan which gives them access to particular resources, not knowing whether they are going to actually use those services, because most of us don't know what health conditions we're going to face in the upcoming year, or

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two or three, and instead we're valuing in some sense the option to be able to get those services. And that can affect the pricing, the nature of the way the negotiation occurs, the form, the various kinds of health plan provider networks, and how those things fit together also on the hospital side.

But even these theories are generally incomplete. Health economics has not developed a good overall view to try to explain how to view these relationships between purchasers, employers and government health plans and providers, hospitals and patients. And as someone who has been trying to work on those questions, I thought it was a lot easier than when I started. I've been working on some complex theoretical models, and it's actually proving to be a lot harder than I thought it was.

So, as a result, this is still primarily an empirical field, where people are primarily looking at data and trying to make assessments from it.

Let me talk a little bit about the sample and data sources of what we've been looking at, and we identified the area of California to look at because the market growth in these network activities was extremely large in the period following 1994. 1994 was the first year that the American Hospital Association started

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systematically collecting information on these network arrangements. And those network arrangements in California started out at a particularly significant level, and increased quite a lot during the period following 1994.

Another thing that we found out after really looking at the data is really how different rural areas were from MSA level data, and so I think it's important when we're trying to look at these questions to kind of separate questions with respect to how they affect rural hospitals and MSAs.

And what we have been looking at is a sample size for California -- 1,493 hospitals. I am going to show you just a little bit of summary data, and that's based on that sample of 308 separate entities over that five-year period. Of course there are mergers during that period that happened, so that some of the actual hospital entities actually disappear.

And we're using AHA data plus this special AHA data on networks which provides some detailed information on network activity and when they're formed, how they're formed, how they're based and a little bit about what they do. And also patient level data.

With respect to networks and market competition, as I mentioned, we really believe pretty strongly in

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this kind of area, especially if we're going to focus on these network relationships, that it's really important to use a patient flow approach. That's especially problematic in California to use more traditional county-based measures where Los Angeles County is huge and counties are of different sizes, and it really creates some problems in methodology, but it's really a process that's worth it to really be able to understand what's going on.

And just as a summary, the Zwanziger approach basically takes producing a Herfindahl index, or HHI -- a sum of squared market shares -- for each zip code in a hospital market, looking at patient origin of where they reside. So, you compute HHIs for each zip code as though each zip code was an individual market.

Then you weigh each zip code in calculating a measure of market competition for a hospital, by weighting that zip code's HHI based on that zip code's proportion of the hospital's admissions. So, you basically then look at building a hospital level, market competition measure, based on all the zip codes that they reach out to.

And then you sum the weighted zip codes. Those zip codes for each hospital come up with an HHI level for each hospital. And what we want to do in

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particular, that's, as I said, been done before, but what we want to do is to focus in on the relationship between system relationships between hospitals, or ownership relationships and contractual or network relationships.

So, as a result, we're going to compute four HHIs for each hospital. Hospital systems represent ownership relationships and networks represent contractual relationships. And some of the usual approach has been to treat the systems as though they're a single hospital in calculating this market competition measure. But what hasn't really been done is looking at the network activity.

And so what we do is actually calculate four different HHIs, one that doesn't account for systems or networks, counting for each locality, hospital, places, as an individual. One that accounts for systems, which is that HHI-S is the one that is most used in the literature. But then also look at one that just accounts for network relationships, and then one that accounts for systems and networks together. And it would help, I think, to just visualize that, because we go through briefly an example, so I am thinking about a particular zip code, just one zip code that has five hospitals in it, A, B, C, D and E. And hospital A has a

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50 percent market share, hospital B has a 30 percent market share, hospital C is a 10 percent market share, and D and E each have five percent market share.

And if we imagine that hospitals A and D are consistent with that hospital ownership together, and then hospitals A and B and hospital A and E separately exist in a network relationship. And we set this particular example out here because it represents the extreme level of what actually happens in the market in California.

So, you do actually see these relationships where you'll have a hospital existing in a system with one set of hospitals, in two separate networks, each with different hospitals, some of which don't actually include the hospital that they're in an ownership system relationship with.

In doing that, then, this just outlines how calculating the four separate HHIs. One, the one in the upper left, that assumes that all five hospitals are individual entities. Then the one next to that on the right is the one where HHI and the network relationship, what we do is we chain these together so we allow hospitals A and B and E to all be chained together essentially in a relationship, some kind of relationship together, and calculate an HHI from that, and then in

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the lower left is looking at it as a system, where we just look at A and D as emerged, and then looking at systems and network activity together, chaining all of these things together, where actually hospitals A, B, D and E are all viewed as one entity, and only C is sitting apart. And getting an HHI there of 0.82.

So, that just gives a sense of what we were trying to do. And then the second piece of that is how to look at inpatient prices and how to do that. The methodology we've been using is the one that comes from Keeler, Melnick and Zwanziger, which is an adaptation of Bill Lynk's model that came before that, which formulates a price index for ten specific DRGs. Hospitals have these complex systems, and what we want to do is in some sense, each individual patient is their own output, but we have a methodology with DRGs that allows us to group those, which again has strengths and weaknesses, but then within that, there's going to be a service mix difference between hospitals, and to try to identify something that's consistent. The ten DRGs were chosen originally by Lynk to try to come up with a set of common DRGs that most hospitals would have activity in that might be possibly complicated, so it's the idea to try to come up with DRGs that aren't just simple cases, but have some potential complexity to them.

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And there's a little bit of debate in the literature. We followed the Keeler, Melnick and Zwanziger approach which excluded the Medicare space, and then calculating average net prices from net approach charges, and then followed a regression methodology to model log net price for each DRG and then build that into a price index.

The ten DRGs are here, I'm not going to focus on that, I just wanted to keep that in the slide. And then there's also a slide here looking at the details of the price index calculation, and I wanted to keep that on there to go into the record, but I'm not going to go through that list in detail, but basically intuitively what it does, it just takes that price and it tries to explain all the differences that we know might affect price that would be other than things that would be negotiated. So that what you have left over is essentially a price index that will wind up, as designed, could line up well against a hospital competition measure to identify things well.

And we do find that this procedure works pretty well, and we were actually fairly surprised, not having done this work this way previously, at how well this process works at purging out the variation that you don't want to pay attention to, and leaves the variation

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that you do want.

This is just a picture to just describe what happens in this California market over this period, and it's actually we're still in the middle of doing the analysis here, so I don't really have results that I would like to present as complete, but I think I can tell a story from here that gives a sense of what was going on in California, and a little bit of sense of the direction of some of the results.

I've mixed onto the same graph two different concepts, one being HHI means, and also the percent of the hospitals in the California market that are members of the network, so the top line there that starts out around 25 percent in 1994 is the percent of hospitals that were involved in at least one network.

That rises very sharply for 1994 to 1996 from that 25 percent to over 40 percent. Then it levels off and then actually comes back down a little bit in 1998. And if you look at the HHIs and the comparison between those, you will actually see a little bit what's happening in this issue of substitutability, versus using a network as a way of generating an ownership relationship you can see illustrated here.

The HHI not accounting for systems or networks is fairly flat, although it drives just a little bit in

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the last two years. The HHI for the network, which is the next one up, rises in the first year and the second year, quite a bit, while the percent of possibilities getting involved in networks is increasing. And then it really levels off. Whereas the HHI looking at system relationships is flat at the beginning, then it, too, starts to rise and rises away and continues to rise in the latter part of the period. Because what's happening is many of the hospitals who formed networks in the beginning, and the reason that drops back down is that many of them then convert those networks into system relationships.

However, to try to sort all that out empirically turned out a little harder than we initially thought, and we are still looking exactly at the form of the model that really illustrates things and holds up against econometric testing to be exactly what we would want to stand on.

But I can say a little bit about some of the preliminary results. First of all, we use a number of other confounding independent variables. We have essentially run the Keeler, Melnick and Zwanziger independent variables as well as some of our own and these are extremely stable across the HHI measures, and there is very little multicollinearity between them.

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So, HHI seems to stand apart as a separate factor that is not really influenced by the other factors, so we move around the model and those other factors don't change them very much. And that's a really good thing. So, whatever we're measuring in HHI, we can be fairly confident that something is there.

The second thing is when we don't consider systems or network activity at all, this is partly because there isn't enough variation to identify anything, we basically find a statistically zero relationship between hospital prices and competition.

However, once we incorporate either system activity or network activity or both, we get very significant positive relationships so that hospital network activity or actually a disrelationship activity generates a positive relationship with hospital pricing.

However, disentangling, which is really what we wanted to do in the beginning and thought we would be able to do fairly easily here, the system and the network effects is proving to be extremely difficult to really be able to tell what's going on. And as I mentioned, some of that is the issue of the difference from the substitute effects, where it's really the case where the network is being performed and that's the relationship that's held through the time series

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relationship, versus a case where what's really happening is the networks form, and that's a precursor to system formation.

So, we're now trying by identifying those hospitals relationships where the network turns into a system, that's helping us to try to identify things a little bit better, but we're still working on that.

So, as I mentioned, some collaborative networks become ownership systems. And I should also note, though, that some recent data reverses that trend, where it seems that although what happened is you had network relationships that turned into system relationships. We haven't actually studied the data in detail. AHA has a little bit more data out, but not really enough to sort of see this, but we have some anecdotal evidence that what's happened at the very end of the nineties and after that has been that the system relationships have converted back into network relationships in some cases.

And then there's a question about whether we'll have enough internal variation to really separate out the network effect on prices versus the system effect, but that's what we're trying to do.

I also, although it's not at the main focus of the study, I also wanted to just comment on the ownership issue which is more, as I mentioned, into

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what's going to be talked about tomorrow, that we do see. There's a significant difference between the nonprofit effect on prices and the for-profit effect on prices. And as I mentioned, that effect doesn't seem to be multicollinear with any of the effects on HHI or hospital competition.

And we do get a slightly higher for-profit effect on prices in the '94 to '98 period than Keeler, Melnick and Zwanziger found in the 1994 and before period.

And most other results, though, were very, very similar to theirs. In fact, the government ownership, which is a negative effect, that they have a lesser effect on prices than not-for-profits or for-profits. We get exactly the same coefficient as Keeler, Melnick and Zwanziger does in all of our specifications. So, that stability is a very strong point how we like to do things.

And let me finish by just citing a couple of things that we're continuing to look at or that might be interesting for others who are interested in trying to study these questions that we are looking at. Obviously California has unique market properties with these high levels and then increases in network activity. The AHA data covering these networks and explaining them

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actually also covers the whole country, so it could be interesting to start looking at other markets as well.

Second is to look at the relationships with who's actually operating the network. The data that AHA collects actually also tells you who the operating officer is for the network and where it's located. This could also give a sense for what's going on, in particular, many of the networks are operated by the chief of purchasing, in which case it's really obviously a purchasing network. Others are operated by the chief of managed care, which really is a managed care relationship to work with the health plans, yet others are operated by the CFO. And also some are operated by the clinical director, the chief of clinical services.

So, there's a variety of variation in here, and we haven't to date taken, tried to account for the differences in networks. And also I think we could look at some more detailed work at the profit/nonprofit issue where there's been recent concerns about aggressive pricing practices that could spill over into higher payments from other payers. And in particular, Medicare, for example, now is thinking or is working on revising their way of paying for outlier payments, based on worrying about those kind of spillover effects.

So, that's the end of my presentation today, but

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I would be happy or be pleased to talk about some other issues on the topics afterwards in the general discussion.

(Applause.)

MR. TOWN: I am Bob Town, I am from the University of Minnesota, and I am very happy to be here. And I get a chance to talk about my thoughts about hospital mergers. I am going to take a slightly different tack than the previous two speakers in that I am going to talk about -- less about recent research but mostly about kind of how I would like to argue that or I am going to argue about how we should think about hospital mergers. And so that's what I am going to focus my talk. Although a lot of what I am going to say is based on research that I have done.

And I think the thing that -- well, there's several things about hospitals that make them unique when you talk about merger analysis, but one of the things that I think is particularly interesting, is that hospitals are forming networks, and I'm using the term networks here in the sense that Jim was using systems, that there are ownership linkages between these physical structures. But these -- so they're forming these networks and they're competing against within HMO networks.

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And that makes the analysis very difficult and different than almost any other industry that I can think of. And so I'm going to talk a little bit about that.

So, I wanted to -- so, when I talk to it, I want to articulate a method for analyzing hospital mergers. And this is kind of -- this method for thinking about them is not just my own, it's come from synthesizing conversations with colleagues at the Department of Justice when I was there, from HMO contracting people, from hospital administrators, from my own research.

So, this is not unique to me, and it didn't come from me. And, in fact, I think various enforcement agencies have made this argument that I'm going to make here on various cases. However, I think the courts have been less receptive to this argument, and I would like to argue that they should be more receptive to it.

I'm going to primarily focus on pricing impacts of a hospital merger. However, I think, you know, economists like to talk about prices because it's something we can measure very easily, but ultimately the bigger concern may be in the quality demand, and there's not very much work done in that area. In fact, I think -- I know of two papers that -- they're up there, that have done some work, and actually, there's a

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broader list, if you were interested, and I could send it to you, but there's very little work done on what mergers do to hospital quality. The Kessler and McClellan paper is in the quarterly Journal of Economics, it's actually a very nice paper and the paper I have with Gowrashankan, it's in the Journal of Health waiting to be accepted and published. And I am happy to send that to anybody who is interested.

Now, hopefully my talk will have some potential pitfalls, I think the courts have fallen into when thinking about hospital mergers. You know, to keep from being specific about what cases those pitfalls occurred in. So, in any merger, whether it's hospitals or any industry, I think the organizing principle is, you know, who are the buyers, what are they buying, and who are they buying it from?

So, in the case of hospitals, who are the buyers? Well, there's kind of three of the kind of big buyers, there's going to be Medicare and Medicaid, which we generally aren't too concerned about on the pricing side, since they set prices, for the most case.

And then there's managed care. I am including in managed care those self-employed insurers who are contracting with hospitals. I'm lumping them in there. And I think it's useful to think about exactly what do

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HMOs do? Well, they do a lot of things, and I think two things that are particularly important that they do that are related to hospital mergers, is that they selectively contract with hospitals. They don't contract with all of them, they contract with a subset of them, at least many HMOs do. And the selective contracting serves a purpose and I think you ought to keep in mind what those purposes might be.

The first one is that it gives the HMO bargaining power. And it gives the HMO bargaining power through the threat that they'll exclude a hospital from their network. And it's that threat that's going to give the HMO the ability to keep prices low. And it's that part of the story that I think drives where the anticompetitive harm occurs.

And there's a couple of papers on that. The paper I have with Greg Vistnes in the Journal of Health Economics, actually this talk is based in part upon, and also some work by Cutler McClellan and Newhouse in Rand.

The second thing that I think the selective contracting allows HMOs to do is it helps them do utilization management, they're able to place hospitalists in hospitals, in which we manage, you know, how long people can stay in the hospital. You have to have a certain amount of volume in a given hospital to

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do that in order to justify the expenditure, and also allows the HMO to exclude those hospitals that they think are low quality.

And there is some evidence, although it's limited, that HMO enrollees go to better hospitals. Mike Chernew and colleagues have a paper on that and Kersey [phonetic] and colleagues have a paper on that.

Now, the utilization management component is actually relatively important, because it's the HMOs making these investments in the particular hospital. And those might not be recoverable if they decide to drop that hospital from the network.

So, I think the best way to kind of highlight -- or at least highlight how I would like to have people think about hospital mergers is to kind of go through a hypothetical hospital merger. So, I have up here my little medium-sized hypothetical city, in which there are hospitals, which are given by the different letters, A through I. The numbers in the hospitals represent market share of the managed care enrollees in that city. With any luck, they add up to one. Or add up to 100, in this case.

The color of the hospital represents which HMO they've contracted with. So, here, HMO 1, which I have in green, they're contracted with hospital A, C, and E,

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and F. HMO 2 has contracted with hospital D, B, and also F. So, hospital F is contracted with both HMOs.

So, if you were doing kind of what I would call an Elzinga-Hogarty kind of analysis that this kind of constitutes a city where, you know, the patient flows are relatively constant within the circumference of the city, and there was going to be a hospital between -- to add a little animation here, there it is, a hospital merger between E and F, you get the initial HHI would be 1450, and the change in the HHI would be 200. Which would be sort of below the official guideline radar, but certainly in practice would be below the guideline radar.

But this analysis, that kind of analysis ignores several things. One, it ignores the nature of the contracting networks that are in place; it ignores the differentiation that's occurring here. Both product-wise, geographic-wise, perhaps quality-wise, which is an important component of product differentiation. And those things can affect, I think, greatly, how you analyze the merger.

So, how should we think about this one? And I think here's the kind of the city down below here in this little corner. And I think the best way to start to analyze the impact of the merger is to think about

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how prices are set prior to the merger. And those prices are going to be set via negotiation between the HMO and the hospital, and that bargaining negotiation is going to be reflected in the value that a particular hospital brings to the HMO's network.

If a hospital brings a lot of value to that network, presumably you get a little higher price for the HMO sending their patients there. So that the value, in this case, of hospital F to HMO 1 is going to be the value of the network that HMO 1, which is the green guys, has from the network of A, B, E and F. But the threat that the HMO has to the hospital is to drop it from the network. And say, you know, we can't come to a good agreement on the reasonable price, but we're going to drop you from the network, and that is going to be the value to the HMO hospital, A, B, E, and suppose that I was the next best alternative to F and they include I in the network.

Post-merger, that bargaining -- the bargaining position has changed. And it's changed because now the threat of hospital F, as they've moved to merge with hospital E, is that they can drop both hospitals from their network. Which means that if they can't reach an agreement on the premium, then the value to the network, to the HMO, is the value of A plus B plus I; in other

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words, they lost E in this circumstance.

So, the net change in price due to the merger will be the difference between the price up here and the price down here, which will be a function of the change in the value of the next best alternative to the HMO.

And I think that's pretty intuitive and I think it's kind of hard to argue that, but where the issues get sticky, and there are a couple of sticky issues, and they're twofold: One is how do you estimate the value of alternative networks? You know, there's two associated problems in that. One is what's the right metric for valuing the network? There's many players here. Unlike cereal, where the consumers of the cereal are paying for it, in hospital markets, that's generally not the case. Consumers are not paying directly out of their pockets for the services.

They're paying the HMO, or the firm, more accurately, that they work for is paying the HMO, to contract with all these hospitals.

So, understanding from whose perspective the value of the network is not entirely obvious. The second is what are the other possible alternative networks? Here I included I as the alternative to E and F, but it easily could be without I, it could be I and G and H, all right, so there's different network

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configurations that serve as the next best alternative to the current network.

Now, in the paper in the Journal of Health Economics, we use consumer surplus of inpatients, and we attempted to measure that. But that's not necessarily the best alternative. It could be the value to the buyers. And probably best, if we could measure it, but it's very difficult to do so, is what's the -- what are the HMO profits from various network configurations?

The next big problem is what's the function F? Now, if you remember, F is the thing that translates these changes in the value of the networks into prices. You may be able to form a measure of the value of different alternative networks, quite easily, or maybe with some effort, but still it's unclear how you translate those things into prices.

For the economists in the crowd, the next bullet point will make sense, for probably everybody else, it won't. And I think ideally, you would like to have F come out of some equilibrium bargaining model that you've solved. That's difficult, and no one's done it. At least in this kind of context.

So, the alternative, there's a couple of alternatives. One is you can look for statistical relationships, which is what we did in our Journal of

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Health Economics paper, or another possibility is you can use the current pricing data to make inferences about what that F function looks like. And talking to HMO contracting personnel can actually tell you a lot about what that F function looks like. And I think it's hard to discount the importance of knowing what that F function looks like and the help that the contracting people can give you on what exactly it does look like.

So, this is the kind of typical non-guideline, and the reason I put that non-guideline there, is because I think the method that I'm outlining here if you think about it is perfectly consistent with the horizontal guideline method.

So, the Elzinga-Hogarty kind of analysis suggests little harm from the merger. However, I took those -- I took some kind of simulated data, and given the results from our Journal of Health Economics paper, and the stimulated data would generate kind of market shares that I put up there earlier, you could expect a price increase of approximately 10 percent from the mergers. Suggesting that that really matters how you think about it.

In our data set, which was also from California, 15 percent of -- we did the simulation where we took everybody, all the hospitals in California, Southern

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California, and we said, geez, you know, let's run some hypothetical mergers. So, we said for each hospital, we picked their next best, their closest substitute hospital, assumed there was a merger from that, and then recalculated the value that they would bring to the network, or actually more exactly, the loss that they would bring to the HMO network if they were excluded from that network.

And given our estimates that we did earlier, about 15 percent of the hospitals that we did this for had price increase -- expected price increases of greater than five percent. And LA is a very -- well, there's a lot of hospitals in an intense urban area and a lot of hospital competition. So, if this could happen in LA, it could happen in a lot of places.

And the reason it's happening in LA is the role of product differentiation and geographic differentiation are very important in determining hospital prices. And we know that in any market where differentiation is important that even if there are a lot of competing firms, that if the right competing firms merge, you can get big price increases.

So, kind of my take-home points here, that I think in thinking about the hospital merger, it's very important to think about product quality and geographic

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differentiation can account for those explicitly in your analysis. I think in any kind of pricing regression, you have to have that incorporated in there somehow.

Restricted HMO networks are the important mechanisms by which insurers maintain lower provider payments. So, it's this ability to exclude hospitals is what gives HMOs bargaining leverage, versus hospital, or vice -- kind of the flip side of that is that what gives hospitals bargaining power is their ability to be essential for a network.

And then a point that I really didn't get a chance to highlight here, but I think is also important, is that actual patient flows may not have a direct and obvious relationship to market power. And you can think of a hypothetical case where two hospitals are right next to each other, right, but one HMO sends all their patients to one hospital, another HMO sends all their patients to another hospital, it looks like, geez, they're pretty much very concentrated places, right, but it would be easy for each HMO to kind of start moving patients to other places.

So, the actual flows may not represent kind of market power issues, but it's what you have to take into account is what could happen if the networks were reconfigured.

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And my last point is that -- or I should say the actual patient flows may actually represent market power, so just because -- just because they can't doesn't mean they don't.

And finally, the given networks that are in place will play an important role in determining what the price impacts of the merger are. So that in analyzing the merger, you have to take into account exactly what the network configuration is going to be.

I should say, and the last point, one of the reasons I think this view has not been adopted is that in a lot of economic analysis, this kind of analysis is not done because the data is not available to do it. I don't think it's because economists think it's a wrong way to think about it, it's just that the data to do this is not available publicly. However, in a merger it certainly is available, and there's no reason why it couldn't be done in a merger. In fact, it is done. And I think I'll stop there.

(Applause.)

MR. BURNS: Well, I agree with everything that's been said.

So much for my spelling.

I'm here to talk about hospital vertical arrangements, the rationale and performance. Before I

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start, let me just apologize for coming in so late, I had class at noon at Penn and it's kind of hard to get down here when you're teaching at noon.

We were asked to address a number of questions, some of which are relevant for hospital vertical arrangements. Just quickly to describe for people what the vertical arrangements are that have emerged in the U.S. market, what are the key drivers of performing these vertical arrangements between hospitals and other players, how they affect cost and quality, how do they affect bargaining power and other competitive dynamics between hospitals and payers, and finally, do consumers, employers or insurers prefer these arrangements. I'll try to go through this pretty quickly. I think the evidence is pretty clear.

First, what are the vertical arrangements that have emerged in the market? I have categorized them into three types: One, partnerships with physicians that hospitals have formed, and I'll go through those a second; second, managed care vehicles where hospitals have gotten into the HMO and PPO business; and finally the whole continuum of care inpatient and outpatient.

First, hospital integration into input and output markets. Here you have the core hospital, it can vertically integrate into ambulatory care getting into

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physician offices and ambulatory surgery centers, various kinds of outpatient care, and then towards the extended care, post-acute care, skilled nursing care continuum.

Hospitals can also integrate into insurance vehicles, as I said, becoming a buyer as well as a supplier of hospital services, and then finally, hospitals can develop the full continuum of care from primary care, specialty care, outpatient care, acute care, home health care and skilled nursing facility care.

This slide came from the advisory board, you may recognize it at the bottom. This is one of their chief marketing initiatives when they tried to get hospitals to think that they could actually do all of these things.

Now, let me just delve down a little bit into the hospital partnerships with physicians. This is the alphabet soup we faced in the early to mid 1990s where the hospital organized an IPA around its medical staff, physician/hospital organization, which was really nothing but a joint venture between the hospital and its medical staff, typically including some sort of contracting unit to go to the market with managed care. Management services organization, a group practice

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without walls, or what we really called a wall without a group practice inside of it. A foundation model. And then the primary care physician acquisition and salaried model.

Now, there actually are data on these, more than the others, and here's what's happened with the hospital partnerships vertically with their physicians, over time, for all those six models, you can see that they really peaked in 1996, and then they trailed off after that. So, 1996 was the peak. 1996 was also the peak for hospital mergers and acquisitions, according to the American Hospital Association's data.

The other thing you see here is that the single most prominent type of vertical integration arrangement with physicians was a PHO. Thirty-three percent of hospitals had a vertical arrangement with a PHO, and a PHO was nothing other than a joint venture with hospitals and physicians to get a managed care contract. That is not what I call integrated health care. That's just forming a bargaining unit to go to the market with managed care.

The other thing you should note is you should not add all those up, you know, in a column to figure out how many hospitals are doing something, because hospitals typically had a menu of these things that they

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were offering their physicians, integration light up here and integration heavy down here, and they typically offered two or more of these initiatives.

Second, what are the key drivers of this behavior? The way I've chosen to answer this question is to contrast the theory versus the real motives behind this. Last summer Mark Pauly and I published an article in Health Affairs which summarizes what I'm about to show you. If you want more information, we published it in the July/August issue last year of Health Affairs.

Basically what you do is if you take what the practitioners argued for why they were doing vertical integration, and then you compared it with the theoretical arguments for vertical integration from the literatures of management, industrial organization economics strategy. You'll find essentially a disconnect between what providers were saying they were doing and what economists and other people say you ought to be doing vertical integration for.

There's a little overlap between these two, but not a great deal. Basically the providers were putting these things together to prepare for and accept global capitation, go on to form large patient pools and provider networks to handle the risks. They said wanted to assume responsibility for the health status of the

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population, but they didn't really know what that meant. They wanted to integrate care and financing, offer the seamless continuum of care, whatever that means, have a future platform for physician partnerships, maybe improve physician recruitment to these fully integrated systems, expand into new markets, and reduce transaction costs. Then there are a whole series of private agendas that hospitals were pursuing at this time, which had nothing to do with what they were actually saying. What they really wanted to do was control referrals. They were afraid of the loss of referrals, so maybe if we get these physicians, we'll, you know, prevent other hospitals from getting those physicians and that's how we'll stem the loss of referrals.

Maybe there was some scale in scope economies, and sometimes these things happened just so one party could cap the reserves of another party. That typically happened when a physician group acquired a hospital, rather than a hospital acquiring a physician group. Physician groups saw the hospital as a boat load of money that could expand the physician group.

Then you have the theoretical argument over here, but basically there's a disconnect between these two, which I find both troubling and not surprising. Troubling because obviously the practitioners don't know

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the literature, and perhaps I shouldn't blame them for not knowing the literature because we don't write it for them. It's fairly obtuse literature. They probably haven't taken a course in the last 20 years in industrial organization economics. But also because we probably haven't been very good at getting in front of them and telling them here's what the academic and the research literature suggests about the strategies they're doing.

It is not surprising because the practitioners tend to jump on bandwagons. They'll listen to what the consultants say, they'll listen to what the advisory board says and they'll jump on to these, fad after fad after fad, in the health care industry. Vertical integration was one of those fads, and the providers jumped on that fad blindly.

And if you look at the diffusion of vertical integration arrangements, it has the perfect shaped S diffusion curve, and there wasn't a whole lot of research evidence, either in industry or health care, to back up why they were doing it.

Now, there were ten assumptions behind integration. This is my Dave Letterman top ten for why hospitals were getting into the vertical integration business. First, California here you come.

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Essentially, a California model of capitated health care was going to come to the east coast. That never happened.

Second, there were four stages that your market was inextricably going to march through. Remember the four-stage market model that APM and the University Health System Consortium were touting, you know, hospitals were running around saying, I'm a stage two market, hospitals were going around, I'm a stage three market, as if that meant something. That whole thing turned out to be totally bogus.

Third, scale economies, the never-ending belief that scale economies exist in the provider side of the health care industry and it turned out to be the Helen of Troy of integrated health care. You know, the face that launched a thousand integrated delivery venture efforts.

Fourth, desperately seeking synergy, okay? Hospitals throw around the words economies of scale and synergy as if these things exist and as if they know what they mean and more importantly as if they know how to get them. But they are looking for synergy and they don't even know what the word means.

Five, they thought by buying primary care physicians they could get the managed care contracts and

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the covered lives. That turned out not to be true.

Six, you can control referrals from the primary care physicians you buy. That also turned out not to be true. We learned this the hard way in Philadelphia and Pittsburgh where we had the Allegheny bankruptcy. In Allegheny, a health plan bought 552 primary care physicians, overpaid for the practices and then said, we'll make it up on the referrals. Okay, they didn't get the referrals, okay? They thought they were going to get 75 percent of the referrals from the doctors they bought. They ended up getting 25, 30 percent, and not much of a jump after they acquired them.

Seven, you can partner with physicians. Okay, this is one of the key assumptions that underlies this literature and I'll show you some data why it's not true.

Eight, HMOs want to partner with integrated delivery networks. That was also an assumption that was not true. You know, the HMOs are just dying to deal with a provider cartel.

Number nine, integrated delivery networks can leverage HMOs. During the nineties when this trend was taking place, that was not true. It may be more true today, which is one of the issues why we're here, but it was not true during the mid-1990s.

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And number ten, the Clinton Health Plan. The Clinton Health Plan helped to launch integrated delivery networks, along with enabling legislation in Minnesota and Washington, both of which were repealed three years later. That didn't matter. And the Clinton Health Plan was never even passed and it launched all of these things. You know, if Bill and Hillary were smart, in 1993 when they floated the Clinton Health Plan, they should have just backed off and not done anything else and they would have been declared a success, rather than having to go through the defeat they suffered in the next year in Congress.

Third, how do these arrangements affect cost and quality? I'm going to quickly summarize the literature. Here again, most of this is summarized in the article I did with Mark Pauly. Now, I'll go through it, different arrangement by different arrangement.

In terms of acquiring primary care physicians. It turned out when you did that, you only got a small number of capitated lives from the managed care companies. You suffered heavy financial losses for every acquired primary care physician. You got estimates up to $100,000 per primary care physician per year, and Allegheny had 552 of those, so do the math and you can see that they had $50 million of debt just from

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that alone.

Small increase in physician loyalty, very small increase. Failure to capture the majority of the referrals that I mentioned, and one study found that acquired primary care physicians had lower willingness to cooperate with the system's practice guidelines, compared to free physicians or independent physicians. Very surprising.

Secondly, when you turn to the physician hospital alliances, the alphabet soup, the IPAs, the PHOs, the MSOs, they also failed to attract covered lives, they had little or no infrastructure to manage any of the capitated risk lives they did get, they failed to increase physician loyalty, they failed to improve hospital efficiency measured in terms of cost per day, they failed to impact hospital quality, measured in any number of ways, no economies of scope, and they actually declined in prevalence post 1996 as I showed above.

Then you turn to hospitals that got into the HMO business. These things were a sorry failure. Hospitals, they were sorely undercapitalized, they had an inability to sufficiently grow and then compete with the larger HMOs which had already consolidated and gotten big. They sustained huge financial losses in the

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early years, huge medical loss ratios, sometimes over 100 percent, no actuarial or marketing expertise, and imagine having an HMO in-house when you have a physician division and a hospital division. Guess who wants the money? Everybody else except the HMO. And so they conflicted over where to spend the money in-house.

And finally the hospital continuum of care efforts. Those efforts were all derailed by the Balanced Budget Act which really cut the rug out from long-term care. So hospitals that got into that, lost their shirt after the Balanced Budget Act. They were also smaller markets with relatively low revenues. There was no IT technology capability in these hospital systems to link the disbursed alternate sites and no economies of scope in combining outpatient and inpatient care.

Fourth, how do these arrangements affect bargaining power and other competitive dynamics between hospitals and payers? This is where it gets interesting, especially in the last couple of years.

First, there have been no empirical tests of these dynamics to date. One study is about to get under way, I believe, between Bob Town and myself and some of his colleagues at Minnesota. There has been one recently published study from The Community Tracking

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Study. It's in the February issue of Health Services Research. It's based on field interviews in the 12 sites of CTS, and it suggests that physician hospital integration can leverage managed care firms.

Now, having studied this literature for a long time, I have two problems with this research finding. First, vertical integration is empirically confounded with horizontal integration. Hospitals got into the vertical integration business the same year that they got into the horizontal integration business, and you can't -- no researcher has empirically separated those two effects. I believe the horizontal integration impact on competitive bargaining with HMOs is much bigger than the vertical integration effect.

Secondly, with this research finding, the reason the researchers, who are all good researchers, assume that vertical integration, vertical integration can leverage managed care, is that they assume that hospitals can align with their physicians and forge cooperative bargaining units. That hospitals and physicians can actually get on the same page and go to the market with a combined face or combined force and actually make a persuasive case for a higher rate. And this, after all, of the theory behind the alphabet soups, the PHOs, the MSOs, the IPAs.

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Let me show you what data we have so far that discounts this. This is unpublished data, it's from a national survey of 12 integrated delivery systems around the country where we surveyed all of their physicians who were in these aligned relationships, you know, the PHOs and the MSOs, those are the physicians who are in integrated salary models, who are part of the hospital hierarchy, that's the bar on the right.

The physicians who are in the network or alliance models like the PHOs or MSOs, those are in the middle. And finally, the physicians who are rank and file medical staff members who are not affiliated with the hospital in any way are what we call the market arrangements.

Now, this was probably the best study of these different types of physicians, because we had a stratified random sample of these and we had the population of these, and then we gave them, you know, a 40-question survey, asking them how affiliated are you with your hospital, how loyal, how committed, how happy, how autonomous, et cetera, there were 12 different survey dimensions, and it was on a Likert five point scale.

One means not at all, two means no, three means I'm not sure, four means yeah, I'm sort of aligned with

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you, and five means yes, I'm on the same page with you.

Now, look across, the average score is three. Now, three on the Likert scale is a question mark. That's essentially you're asking the physician, are you loyal to this hospital? The physician goes [shrugging shoulders]. Are you committed to working with this hospital? [Shrugging shoulders.] Are you ready to invest in developing new ventures with this hospital? [Shrugging shoulders.] It's a shrug factor. Physician says, I don't know, and perhaps I don't care.

Then you compare, well, we're buying up all these physicians in the hierarchial arrangements and we're setting up all these strategical alliances in the network arrangement, do we get better performance out of those than the rank and file physicians on the medical staff? What do you see? Not much.

Now, we had a huge sample here, almost 2,000 physicians. Some of these little deltas in here are statistically significant, with a huge sample. But the question is, are they substantively significant, and are they worth spending all that money on? I don't think so. And I don't think those deltas are substantively significant.

Now, I can imagine one scenario where a hospital physician integration might have some leverage over

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managed care. If the hospital partner is the dominant player in the local market, a large hospital system, the must-have hospital and an insurer network, and the hospital has a very large network of primary care physicians which are both owned and contracted, then the insurer may be afraid it will get locked out of the doctor market if it doesn't do business with the hospital partner. And that, in fact, is what the CEO of Tufts Health Plans said to the FTC a few months ago in their dealings with Partners Health.

Now, I think that is an isolated instance, because how many hospitals in a local market have the clout and the prestige and the must-have status of Partners Health Care? And how many hospitals in a local market have 5,000 contracted physicians like Partner does with its PHCI network? I don't think this is a generalizable phenomenon, but I could be wrong.

Now, I've already talked a little bit about this, what happened when hospitals went into managed care, what's the competitive dynamic there? Hospitals went into that market essentially to vertically integrate to compete with the people who used to buy services from them, the commercial plans. They wanted to cut out the middle man. They wanted a countervailing force against the middle man. They wanted to capture

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the additional margins, they wanted to pay themselves more money, I don't know where that money was going to come from, but they thought, we'll cut out the managed care margin and just pay ourselves higher rates. They wanted to get experience with risk contracting and position themselves as the ill-fated provider sponsored organizations from the Balanced Budget Act.

The problems as I have mentioned before were numerous. I counted up at least 30 or 40 different problems these hospital-sponsored health plans had, any one of which would have sunk these things.

Now, finally, do consumers prefer these arrangements and do employers or insurers prefer these arrangements? Let me ask you the first question first. Do consumers prefer these arrangements? Well, when was the last time you went into a doctor and asked for integrated health care? It's a dumb question. There are only a small percentage of the population that needs to have the coordinated continuum of care, typically for chronic conditions that persist over some point in time.

So, for the vast majority of patients, typically those under 65, integrated health care is a nonstarter. And secondly, what about everybody else? Well, consumers don't really know integrated health care firms exist, thus they don't demand them. Some employers like

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BCAG [phonetic] view them as wasteful and duplicative, especially when they establish the same type of organizations and infrastructure. Insurers view them as contracting cartels that seek to extract higher prices in exchange for no value added. And I said there are no performance results and so I challenged the providers to make the case that they indeed add any value.

Thanks.

(Applause.)

MR. HYMAN: Okay, we're going to take about a ten-minute break, and then we'll reconvene at 4:00 for some roundtable discussion. Thank you.

(Whereupon, there was a brief recess in the proceedings.)

MR. HYMAN: We have some time for a roundtable involving all of the panelists, and Scott and I have a number of questions that will hopefully kick off the discussion, but before we do that, we wanted to sort of give some time to each of the panelists, if they wanted to ask questions of any of the other participants or sort of frame a subject for discussion, since you all are certainly experts in your respective fields and we're just official interlopers. So, why don't we start again at the far left and just ask Bob if there's anything he heard that he would like to ask questions

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about, or whatever.

MR. HURLEY: I guess I just wanted to mention, and I mentioned this to Rob during the break. I think that there are some exceptions to the nobody's integrated and nobody's made it successful. I think -- in fairness to the mother of all integrated systems, Kaiser California -- is an example of a system that does achieve integration that gives that name respectability. And I think when it actually registers with consumers; I know in our visits to California in looking at the Kaiser experience, it really is a sense of one-shop shopping and does offer a credible continuum of care.

So, I think, rather than suggesting that this is an impossibility, I think it's a rarity rather than an impossibility.

MR. BURNS: Full agreement.

MR. HYMAN: Well, let me just follow up on that, why is it a rarity as opposed to a nonexistent possibility? I mean, what are the conditions in California and elsewhere that justify its, you know, its continuation in this marketplace?

MR. HURLEY: Well, I think particularly Kaiser has 60 years of history, which is hard to discount when it comes to its capacity to do this. I think it also does have a unique "compact" I guess is the phrase they

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use to describe the relationship that they've been able to really meld between physicians and the health system that goes back almost 50 years itself, and that relationship has matured and evolved over time.

It's also a system that has a great simplicity when you think about how it's being paid and how it is able to take capitation, an exclusively capitated system. It's not dealing with multiple revenue sources and methodologies for payment; it actually is the simplicity of it allows it to flow the dollars into the system and distribute it to cost of care. So the notion of pure management is fundamentally different from other aspects of management.

I think also at the same time it's a market that -- or it's a system that suffers from its inability to be transported across the country. That's the uniqueness of the circumstances under which it has grown. So, its lack of success in other markets has been sort of sui generis in that respect.

MR. BURNS: Can I add one thing to that? I need to be more fair, too, and I should have known better, because I actually put it in the article that I wrote with Mark. There are a handful of other examples like Kaiser around the country, but they all have the same characteristics, which I do not think can be duplicated

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by very many other people.

The others that are like Kaiser around the country are Geisinger, which is in beautiful Danville, Pennsylvania, the next time you're on route 80 in the center of the state; Carle Clinic, which is Champaign/ Urbana, Illinois; Scott and White in beautiful Temple, Texas; the Marshfield Clinic, perhaps; Oxner Clinic, perhaps. You can count them on one hand, at most two hands. They all have a core set of characteristics which distinguish them and give them strategic advantage.

Typically, they are located in rural areas, hardly any other competitors. They launched -- they were launched on the basis of a large multispecialty group practice in the twenties or the thirties, and so over the last 70 years, they've all developed a physician-centric collegial culture, which you won't find anywhere else. And on top of that physician multispecialty practice, they built a hospital or hospitals, and then they all got into the managed care business around the 1970s, long before anybody ever did. And, thus, the physicians have had 20 to 30 years of experience and comfort working with managed care, became more managed care friendly, and they have a captive HMO and a captive market where they could get the HMO out

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there and penetrate the market with no competitors on either the Blue side or the for-profit commercial insurers.

So, they've had 20 to 30 years to develop all of these things with no competition, protected markets, and have built the capabilities in-house over an extended period of time, which anybody getting into the business in the 1990s just doesn't have that historical track record, doesn't have the physician culture, and doesn't have the time -- doesn't have the time advantage of developing all those things. And those things cannot be easily duplicated, especially when you're in a hurry to wrap up an integrated delivery network and do it on the cheap and do it real fast and then on top of that the providers in the urban centers don't make them physician centric, they're all centered around hospitals, and everybody else distrusts them. So, that's why these things just aren't exportable, and Kaiser was built the same way.

MR. BURGESS: A couple of comments on the discussion that was just bouncing back and forth. One thing related to the network issue that I was discussing, the noncontractual -- the contractual relationships. One of the other aspects that's important to understand about an organization like

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Kaiser, is at the health plan level, they're the ones that are explicitly out of the kinds of collaborative relationships that are forming at the health plan level in like California.

So, one of the other things you see is that when an organization like Kaiser forms and does what it does, it also tends to go it alone in other ways, in contractual ways as well. So, I think that's an important characteristic, and I agree with everything else everybody was saying on that.

I guess the second thing I would add is this issue about the relationships within the organization. I think it's really important to keep in mind that I think the issue that is about physicians and the organization is not just getting the physicians together and being physician centric, but the other problem in these large organizations, when you merge them together, is that physicians don't control all of the economic and health care activities in the organization, and it's actually also that the physicians don't necessarily hook up with the other constituencies in the hospitals or health plans or other places all that well either.

So, I think it's these organizations are just really complex and we don't understand them very well. I don't think any of us really understand how they

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actually work and how we actually get patient health care out of them.

I guess, the question I would like to ask is a little bit of Bob Town and some of what he was saying. I really liked his model. I wanted to make one connection point is that when he was talking about that equilibrium bargaining model, that was the same thing that I was talking about when I also referred to a theoretical model that wasn't out there. That was the exact same model I was thinking of.

And as someone who spent the last year trying to build such an equilibrium bargaining model off and on, I think it's really important, but really hard to really understand in a conceptual way what's really going on is health plans and providers are competing with each other.

And again, it's an area we really don't understand, but it's really crucial to really get a sense of what the key friction point in the markets are. And I think most of us would probably agree that that's a key friction point, but not about how it actually works. And I guess the question I wanted to ask Bob was about when you were talking about the -- it's sort of a question about the ex post view about the patient flows. Your little picture that you put up there was sort of an

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ex post, I mean here's the realized levels of where patients end up in these hospitals.

And it's also, and I know you're familiar with it, but the ideas of the option of demand ideas that, you know, it's sort of more of the case when the network is setting things up, they're trying to set up the options to use things, and we don't really know -- the patients going in don't always know what services they're going to need, and similarly the HMO in setting up its network doesn't know exactly which patients are going to need things.

Do you think there's any usefulness in thinking about those conceptions from an ex ante point of view or do you think the ex post view is better?

MR. TOWN: Well, I think on the option demand side, a lot of large numbers kicks in, so that in the aggregate that's not an issue, that you don't have to worry about it. The HMO doesn't have to worry about option value because it knows it's going to have the 35 bursts. So, I think at a meaningful level, I think that's not -- it doesn't contribute to the analysis.

So, and I think the ex ante versus ex post, it's hard to get to know the ex post, when you're ex ante. So, I think that's the big problem.

MR. BURGESS: Okay.

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MR. HYMAN: Bob?

MR. TOWN: My question is actually more of a magnitude question, one for Jim and then one for the other members of the panel. And the one for Jim is I was curious as to what kind of magnitudes you were getting on price effects and what it would say about various types of vertical or vertical and horizontal arrangements, I guess more horizontal arrangements, that we should be concerned about and which ones we shouldn't be concerned about. And then the question for the other two panelists would be what sort of magnitudes do you see of price effects from vertical arrangements in the literature of the stuff you've done?

MR. BURGESS: Well, I guess I'll answer your direct question first. I was kind of hoping to avoid being pinned down because we're still doing some empirical. That's okay, I'll let you try to pin me down. I mean, roughly what we were talking about is if, for like a -- viewed at the -- for I guess a ten-point -- actually, no, 100 -- I have to think about it. Let me put it in percentage terms, because that's the way we've been looking at it. For a 10 percent increase in HHI, that can result in something approaching a 10 percent increase in prices.

But as I said, only once you're accounting for

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either systems or networks. There's some kind of accounting for the relationships between the hospitals. So, when you do them as independent local entities, because one argument you could make is that that base level, without accounting for systems, because the system hospitals are still free to set different prices. They don't necessarily line up their pricing schedules. So, you could say, you know, that they aren't really exploiting that market power, but it really is that market power seems to have that effect.

Did you have a second question?

MR. TOWN: That's for the other guys. The impact of vertical arrangements on prices.

MR. BURNS: I haven't seen any data.

MR. HURLEY: I haven't either, yeah.

MR. HYMAN: You didn't hear anything.

MR. BURNS: I didn't hear the other three presentations, so any questions I have are totally uninformed.

MR. THOMPSON: Well, I have another follow-up on the discussion we just had about option demand and relating to patient flow. How do you incorporate into a view of the world that either looks at the law of large numbers, or take the ex post view of the data directly. The notion that there are quite a few consumers out

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there who are not actually using any substantial amount of hospital services for substantial periods of time and yet are paying money into the system through their health care premiums. These may be quite desirable from the point of view of the HMO customers that were the primary focus in the discussion, and I think implicitly the other discussions as well, and yet they don't show up in patient flow data at all.

So, if you could comment on if there's any way to get them in somehow.

MR. TOWN: Well, the answer is there's always a way to get them in. It's whether you can get them in in a way that you're happy with. I haven't spent a lot of time thinking about these option demand issues, mostly because I tend to view that, you know, if you're talking about populations of 100,000, in a particular HMO in a particular city, you're going to have the whole variety of the average outcome is a pretty good proxy for what you should be worried about.

But I might be wrong in that, and I just haven't really thought it through as carefully as I should to give a good answer.

MR. BURGESS: Let me give you my counterargument, I guess it would be. What I think the issue is is that even in an empirical basis, we haven't

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really been looking at the problem simultaneously on multilevels, and I'm as guilty of that on what I've been doing as anybody, but it's the issue that if you really -- and part of this problem, of course, is having good data. Historically we've had much better data on hospitals and haven't had very good data on health plans, and where health plan people are located.

One of the things, I think, if we're really going to look at health plan mergers, which is another aspect of stuff or things that are going on, I think one of the things that kinds of data that should be collected by the courts and things in trying to look at that is to really understand where the patient -- where the patients that are enrolled in the HMOs actually live, and then looking and relating that to, you know, where they go and seek primary health care, where they go and seek specialty health care, where they go and seek home health care, you know, the whole continuum. And then try to get a sense for those complexities.

But I guess more directly to the question, I think it's the option demand issue builds in once you are really trying to understand how the health plan and the hospitals are competing with each other as, you know, for their various market shares. Where health plans are trying to gain revenue from enrollment of

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patients and providers are trying to gain revenue from services or perhaps from capitation. Meaning how they're paid.

And it's that bargaining that's happening going back and forth that we don't understand very well theoretically, and people haven't really explored it very well empirically. So, we're actually laughing here because, for the people on the phone, there's a fly that's running back and forth between us.

So, as I said, I think the challenge for the academic community is to look at some of those issues more, and also, I think for the courts and the practice community to be starting to pay some more attention to trying to look at the problem on the multilevels at the same time. And I don't think we've done a very good job of that.

MR. HYMAN: Okay, well, I just succeeded in killing the fly, so I get to ask the next question. But that implies nothing about the quality of the question, I'm afraid.

This is actually, I think, primarily for Bob Hurley, although I think anybody can take a crack at it. Typically when the agencies are looking at merger proposals, there are a range of justifications that are offered, efficiencies, and in particular the elimination

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of redundancies are usually high on the list of the things that are offered in justification of what's sometimes a quite problematic merger, and I guess the question is in light of what we've heard about predictions of people putting their hard-earned money into both horizontal and vertical arrangements, and actual consequences. How much credence should we give ex ante predictions of efficiencies captured and redundancies eliminated given the record of horizontal and vertical integration?

MR. HURLEY: Well, I guess the short answer is not very much, based on what we've seen. Again, I think Rob is sort of posing that people are saying they're doing this more relative to the theoretical arguments, I think illustrates the fact that some of this is clearly, I mean, it's a public assumption. And I think there also is an element that the expectation that acquisitions in a horizontal sense would, in fact, be achieving this, we find that a number of these systems that have done acquisitions have difficulty in achieving and rationalizing that they've intended.

So, the motivation for a weaker facility or a smaller facility to affiliate is often for bolstering and they may actually enter this transaction with a different set of expectations than the acquiring

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facility. And I think many of these facilities have discovered the, you know, the competing heart problem for the hospitals is a very hard thing to still, and so consequently they've ended up making an investment.

We also have clearly seen situations where the vertical -- the horizontal relationship bolsters the negotiating capacity of the system in such a way that they can sustain weaker facilities that become part of these systems, and thereby it becomes kind of a self-fulfilling prophecy that they got what they wanted. As a result of getting what they wanted, they could go on and continue life as has been. And so there hasn't been the collapse in consolidation that's followed on.

MR. BURNS: Yeah, the only thing that I would add, I agree with everything Bob said. I actually had another side on the horizontal integration side showing the disjunction between the two. Typically there's a public agenda and a private agenda, and there's a mixture of the two. The public agenda is usually, you know, economies of scale -- I'll talk about the horizontal side. Economies of scale, efficiencies, cheaper care for us to produce, cheaper care for the people who are paying for it.

And, you know, typically they're saying, well, you know, we'll rationalize capacity, we'll integrate,

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whatever. Typically, there's a conflict between that goal and another goal that they always espouse, and that is: We want to expand our service delivery network. Now, if you're really going to get serious about closing down beds or maybe closing down excess capacity, what you're going to do is you're going to take capacity out of some portion of the geographic market, but then that opens up a hole in that geographic market and you've just shot yourself in the foot in terms of expanding your service capacity.

So, those two goals are in conflict with one another, and when push comes to shove, they maintain the service capacity. One, because that's their goal, and second, if they remove the service capacity, someone else will move in and take away some of their market share. And so, no system wants to do that. So, that's one of the problems.

The second bigger thing is with regard to these justifications, or these hypotheses, that these executives have. I'm convinced, and I've said a lot of strident things here, I'm going to say a couple more. I don't believe executives know what they're saying when they say we're going to achieve economies of scale. And I don't believe they know how economies of scale are actually achieved, and just how limited they are in

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labor-intensive industries.

The second thing is that they'll say other things like synergies and other magic words which they pick up from consultants and gurus and even academics. And I don't think they understand what those terms mean either, but more importantly, they don't understand how you actually achieve them and then how big the savings from those things are.

So, I don't believe anything that they say up front because I don't think they know what they're talking about.

MR. HYMAN: Tell us what you really think.

MR. THOMPSON: I guess I had a question for Bob, in terms of the implications of your theory for how we ought to think about market definition. Obviously you're down on Elzinga-Hogarty, but it wasn't from -- and you feel that your theory is consistent with standard merger guidelines market definition ideas, but it occurred to me in thinking about the examples that you put forward that I would have to define a separate market for each HMO. In contrast, I believe, if I were to use Jim's HHI, it would be a different market possibility to use either one necessarily completely consistent with existing guidelines as I see it, unless we define each HMO as its own market, for example, as

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the center of some market.

MR. TOWN: I think on the guidelines side, I think -- boy, it's been a while since I studied it, but I believe there's -- I mean, there's a lot of price discrimination going on on the hospital side. So, I think there's part of the guidelines that talks about how you define markets when there is price discrimination going on. I think that it allows you to do it at kind of the customer level. So I think that's kind of part of the guidelines that kicks in. But I think using guideline analysis in what I did, you know, the two hospitals that merged would have been a market.

And the problem with Elzinga-Hogarty is that there's -- it's defining markets on the basis of flows, but it has no relationship to prices at all, which is the basis by which you would like to define markets. And that's the fundamental problem with Elzinga-Hogarty. I think conceptually it's fine, as far as you want to identify markets on the basis of where people are going, or where they would go under different scenarios, but it doesn't incorporate the price dimensions, which is critical for understanding where market boundaries are.

Does that answer your question?

MR. THOMPSON: I think so.

MR. BURGESS: Well, I guess I would just add to

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that, I mean, I would agree mostly with what Bob Town said in his answer, I guess I would add to that that it's the same issue of the challenge is it's kind of like how do you -- I don't think we know yet how to simultaneously, and I don't know how to do it, simultaneously sort of look at the network at the health plan's market share and its market, and then also be looking at the hospital's market. And in some sense, if we believe that a lot of the things that are happening in health care that are important are contractual relationships, that may not be ownership relationships, then it does matter if I'm looking at a -- Let's flip it back to the health plan merger, if I'm looking at a health plan merger, it doesn't matter what network of providers they've contracted with. What multispecialty or single specialty group practices, what hospitals, in what markets, and what the nature of the competition of those hospitals and physician groups in their markets is, also impacts how you want to view the health plan merger.

I mean, and those two things interact. I think we haven't, you know, so I think the -- to me the answer to your question is I would look at the whole situation when you're looking at a merger. And especially, and the higher up in the food chain, the higher up you're

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also talking, you know, at health plan level, I think there is more of an importance to look at the provider networks. And if you're looking at a provider network relationship, you might to see, you know, how it interacts with the health plan, but probably less important, which is why historically we've looked at those things and ignored them. I think ignoring it is too far to go, but you can see why it's less important.

MR. HYMAN: This is for Robert Burns. You said that in response to the question, "Do patients want integrated health care," look at what they know, and what they're asking for. And for the vast majority of patients, they don't have the faintest idea and they're not in the slightest bit interested, although you then immediately noted that perhaps people with chronic conditions might be more interested.

And people with chronic conditions account for a substantially disproportionate percentage of use. And so, the obvious question is, is there a market niche there for integrated health care to serve, and is it sustainable given the comparative size? And anybody can take a crack at that one.

MR. BURNS: Well, you know, there is a market niche, but there can be niche firms that can do that. I mean, that's what the forts demise, that's what

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HealthSouth was doing was taking over the chronic rehab or acute rehab market and they developed that. Then you add MedCath taking the heart thing and trying to integrate that across all the different kinds of heart services. So, if there's an opportunity there, the niche firms can arise and exploit that and HealthSouth did quite well for some time. MedCath is still out there and doing well.

So, there's a market out there. But I don't think everybody hospital in every community needs to be developing an IDM to serve that niche.

MR. HURLEY: I was going to, I guess I would plug it just a little differently. I think there are certainly risks associated with becoming very good at caring for very sick people. And I think in the absence of a risk adjustment at the private payer level is that there's a significant concern shared by integrated systems like Kaiser that it behooves them to be worried about that.

I think I wanted to mention something that relates perhaps to several of these questions is that I think we have to recognize that when you use the term health plan, and when you use the term HMO we really mean health plan, and when we say health plan we really mean multiproduct firms today, and multidiverse networks

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associated with this multiproduct networks, because I think that this issue of the degree to which plans are selling more heterogenous products today is very significant.

I know in California today there's a serious concern for a plan like Kaiser to be the last comprehensive benefit package in the market, as everybody else is moving toward bundled and lower cost products. So, I think this idea of becoming very proficient at caring for needy persons carries with it added risk as we go to more fee to user based designs on our products.

We're seeing this in terms of the way networks are being contracted now, and as you look out and look at more of these consumer-driven variant products coming along or tiered networks and arrangements, you're seeing plans develop really finely articulated relationships with provider networks that are built around the suspected risk dynamics associated with this. And I think it's going to complicate the ability to understand these relationships between health plans and providers, in important ways, but that seems inevitable at this juncture. The HMO is in most of our markets, and our 12 markets is a dead product in probably 10 of them or 11 of them, there's nobody buying it anymore, everybody has

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moved on to something else.

MR. HYMAN: Let me follow up that, which was the next question that I was going to ask. How it changes, and I think some of this has been discussed already, the demise of capitation has obviously sort of a baseline tradition where it's dramatically transformed who the providers are and what they look like. And I guess I would like to invite each of the panelists to talk briefly about the extent to which the rise in point of service options, consumer directed health care, and whatever is the next thing coming down the line might change the dynamics of the marketplace.

Bob, you've actually already talked a little bit about that.

MR. HURLEY: I think I would go a little bit further in saying that we're looking at kind of gradations of membership, almost, in terms of network at this time among providers. And part of that is these other products, other than the HMO, have less steering associated with it and therefore bring less value, less certainty of value to the plan -- to the provider networks, and therefore the provider networks expect to be able to relinquish some of the discounts that they've been getting.

So, understanding that and appreciating how the

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claim or control that a health plan has on providers as a result of contracting for less certainty prepared will actually dilute the relationship that exists among plans, and also corresponding to that is more cost participation by the individual consumer, then puts them, that makes them a more influential player in actually the relationship that the delivery systems are going to be having with the health plan. So, I think it's sort of a two-pronged approach: A weakening of the linkage between the plans and the systems; and possibly, it depends on whether the information flow supports decision making by consumers. But I think consumers will, in fact, play a more prominent role in the sites of care and the pursuit of care than they have under this past decade of comprehensive health plans.

MR. BURGESS: Well, I think one thing to note, I mean, this is not a unique view, I think pretty much most of the panel probably shares it, is that the incentives under capitation were, in some sense, doomed to fail from the beginning, just as the incentives in the fee for service were destined to fail. And the problem, of course, is that the incentives in capitation push you toward too little care and the fee for service pushes you toward too much care. And economists have been arguing at least since the eighties, but probably

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longer back than that, that you wanted some kind of mixed system that balances those incentives.

And a lot of it -- there's been a lot of theoretical talk about how you would actually take and use risk adjustment and other methods like that to try to come up with a good mix system model for how you would pay -- how you would pay for health care. And fundamentally, I think, again, that runs into the problem that you need to understand better how to deal with all the multiproduct aspects that have been hard to deal with.

So, I think when you talk down the road about looking at consumers getting more involved, I think most all economists view consumers getting more involved in making choices that we can then look at so to understand how they made choices is generally a good thing. And then how we move from that to how we can get the health plans to balance into that I think is the challenge. And that is, you know, the direction to go is to then start thinking about how to balance capitation and fee for service incentives in some way so that you can get more efficient care.

MR. TOWN: I just have a couple of thoughts. One is that as HMOs, I guess that's the code word, but since they're dead, health plans, as they move to more

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diffuse networks, the role of competition will probably because heightened, because the value that you have -- that a particular provider brings to the network increases, because you're loath to exclude them.

And so, given kind of the simple model I put up, I think you would imply that the plan would be even more vigilant about maintaining competition in a provider market. The second thing is that one of the reasons that capitation failed was not because it was such a bad idea, or mixed capitation failed, it just got too confusing because every health plan was doing a different form of it. Physicians had, you know, ten different contracts with ten different forms of capitation, which, you know, they couldn't make sense of. And so it was not so much that the capitation was providing the wrong incentives or couldn't be workable, it was not workable given the complexity of the contract and the environment.

MR. BURNS: The only thing I would add is sort of from a more global perspective, is the impact of the economy in employment, on whether or not people go into HMOs versus PPOs and POS, that's a definite relationship. The other thing, and I just noticed this, is that the semblance of HMOs by the mid-1990s, I think the HMO model peaked in popularity around '95, '96, if

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I'm wrong. That also happens to have the trough in the underwriting cycle. So, as the HMOs cut their rates and the underwriting margins went down, their popularity hit its peak at the same time when the trough of the underwriting cycle, then the underwriting cycle comes up and the HMO popularity goes down.

So some of the more macro factors to keep in mind in terms of forecasting what's likely to happen, it would be what's happening with the economy, what's happening with employment, and then what's happening with the underwriting side, because I think all those things are tied in together. But your colleagues are more expert on this than I am.

MR. THOMPSON: I had a question for you about some of your conclusions about what hospital network managers and CEOs know, and also about a second question about whether or not patients care. Let me take the second one first. As to whether or not patients care, in at least one hospital merger that I worked on, at DOJ, the department went into court and argued that the relevant customers for the hospitals were not patients, but rather the HMOs themselves or managed care. Is it true that managed care doesn't care about vertical integration?

MR. BURNS: They -- I agree with your first

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point that the patient -- the patient is not part of the equation with either horizontal or vertical integration. I mean, CEOs talk a game about seamless continuum and we're assuming responsibility for health status, but at the end of the day, these things are put together for market power to attract physicians or something else. The patients are secondary.

HMOs do care about the vertical arrangements, only to the extent that they know that the hospital and the contracting vehicle are going to come back to them asking for a higher rate with no justifiable reason. And so the HMOs look on these things as provider contracting cartels, looking for a higher rate.

And by the way, I didn't make this up, this comes from interviews with all the health plans in one very large midwestern city. So I'm not making this up. So, they look at them as contracting cartels with no added value and potentially, you know, restraining trade.

Now, I don't think they have the ability to deliver on that, except in some very unusual circumstances. But, you know, maybe it's the perception that's more important than the reality. Maybe just the fact that they put these things together strikes a little fear in the health plans and that has the desired

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effect. I don't know.

MR. THOMPSON: Before I ask my other question, does anybody else want to respond?

MR. HURLEY: I wanted to use just the example of the PHOs, because Rob you didn't hear me say this earlier, but there are some lesser markets where we're finding PPOs extant. And I didn't mention the specific areas, but there are some examples where PPOs are the entree; the bigger plans are basically ignoring the protestations of the PHOs and saying we want individual contracts. And so basically these organizations may ostensibly be vertically integrated, but from the plans that don't agree to deal with them, they are not integrated, so they can see right through the argument.

MR. TOWN: I know one large health plan will contract directly with physicians, only with physicians within a medical group; they won't even contract with the medical group. They will bypass the group and contract with physicians. So, there really is a drive by health plans to bypass these kind of vertical arrangements.

MR. BURGESS: I might just add maybe a question for Bob, one of the things that you didn't really talk about when you just went through that example was the role of the teaching hospitals and the academic medicine

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PHO model. In the PHOs you're looking at, did you see any tendency for the PHOs to persist in academic medical centers versus nonacademic medical centers?

MR. HURLEY: Well, whether you think of the faculty practice plan as being PHO or whether it's actually meant as a group, the one at least that comes to mind is the organized medical group. They actually do negotiate as a group and they're recognized as a group per se, not even as an IPA, but as an organized medical group.

I can't think of any. There may be some instances where they're structured as a PHO but for all intents and purposes at least the core faculty are presented as a group rather than an organized entity and something that can be ignored.

MR. BURGESS: And then in those group practices like that, are they -- are they falling apart anymore or less than the other?

MR. HURLEY: The academic medical centers? No, I think that -- I think what Bob was saying earlier is that I think that it is true that plans in some cases would prefer to have individual contracts if they could, but our experience is that most plans, if it's an organized group, organized literally as a multispecialty or even a single specialty -- well, particularly

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multispecialty group, most of the plans are okay in recognizing them as an organized entity, it's the -- it's the weaker, looser negotiating front that they're opposed to. And that, I think, is problematic.

MR. THOMPSON: A second question has to do with the assertions you made about the economies of scale and scope. As an economist, I try to transcend that when I moved into cost functions, and in particular the standard simple model of constant marginal cost that we often use.

Is it your perception that they simply don't know what they're talking about, they don't know whether or not these economies are achievable or that they really are not able to get them, they're not there to be achieved?

MR. BURNS: Before I answer your question, let me just say, I'm probably the only token behavioral scientist up here, I'm not a card-carrying economist. I do like the use the term economies of scale and I do think I understand what it means. I think the answer to your question is both. I don't think they know what these terms mean; I don't think they know very well the different ways that you can achieve economies of scale; and I don't think they know just how big or how small the economies are through the various ways you can

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achieve them. But secondly, even if they do, the -- you know, let's assume that the benchmark is 85 percent of your costs around the clinical side. Well, to really cut costs and achieve some economies of scale, you have to do the real clinical integration of merging some clinical operations across sites. Now we all know from the CTS studies and other studies that that is hazardous to your tenure as CEO, and you typically get fired if you try to pull that off and it doesn't work. Because it's very hard. And the only times you can actually do that clinical integration that's physical consolidation is where the two hospitals, let's say two hospitals, are close together, so you don't disrupt the patient and the physician travel patterns. And secondly, there's got to be like a burning platform, in other words, the thing is going to go under, so you can use that as leverage over the physicians to do this sort of consolidation.

And there are going to have to be some other kind of things to go along with it, but very few mergers fit that profile. And so that's why, and plus if you shut down clinical services in a distant hospital, remember you're reducing your service capacity over there, you're going to see market share over there. So, I think hospital executives can't or won't do the hard things that's needed to pull off the economies of scale.

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I could be wrong, you can ask the other three.

MR. BURGESS: Well, I'll jump in on that sort of cost function, the economic cost function idea. When you estimate hospital cost functions, I think there's a number of issues and factors that come into play that I think even establishing or questioning -- I think I would question the idea. I mean, I've done, I've tried to do it, so I know, I mean, I know what you're getting at, but if you're trying to sort of think about what the marginal cost actually measuring it, and then making the assumptions that you're making, start to get really problematic. And just to cite one example, one of the papers that I've done in that area looks at trying to incorporate quality, and in an expansive way tries to say, okay, what happens when you try to add quality to cost function and figure out what happens.

Well, it turns out that the -- you can show pretty clearly once you go through it is that the quality is really measuring unmeasured case mix. However much case mix you measure, that you didn't measure enough case mix, then the quality measure is just again more case mix. And apart from that there's probably even more case mix that you didn't measure.

So, the problem is that even trying to understand from that perspective, and we all understand,

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you know, all of us economists like to think we can simplify the world enough to still be able to figure out a marginal cost, it makes it really hard to relate that.

So, I guess, that would be my, you know, I think if you're going to do that, be real sure you're measuring quality, at least in what you're doing, and of course the hospitals themselves are struggling to figure out how to measure quality. So, they don't really -- because they don't really understand their own case mix I guess is what it gets back to.

MR. TOWN: I think it's unclear why they need the merger to achieve a lot of these economies of scale, there are other vehicles to achieve it that you don't necessarily have to have full integration of facilities to do it. So, again, that would be on a case-by-case basis, but even if they were there to be had, it's not clear that the merger is the right way -- is the necessary way to go to get them.

MR. HYMAN: Let me actually follow up on Jim's point and ask on quality and ask Bob Town a question about quality. When you were talking about how to do the analysis, you said you have to explicitly account for quality differentiation, if I heard you correctly. And, you know, quality is very hard to measure. There are different measures one can use, there are

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aggregation problems, there are risk adjustment problems.

What sorts of measures are you thinking about and how should they be factored into the analysis? Are we talking about process measures or outcome measures or organizational measures?

MR. TOWN: Well, I was actually having in mind, the most simple measure, and that is how are -- how do patients view hospitals? How desirable are hospitals to patients? So, how are they determining which hospitals they would prefer to go to? Which is for those who have an unferreted access to any hospital, which ones are they choosing and why.

So, that's the sense that I had, because that will ultimately determine the value a particular hospital brings to an HMO network.

Now, that being said, once, you know, if we had the ability to measure hospital quality well, which we don't, and given that we could do that, insofar as that would affect patients' views of the hospitals, then that kind of analysis probably would have to be done. But because hospital quality is so difficult to measure, and I've spent some time working on that problem, and it's very difficult to measure in just the simplest cases. It's even more difficult in the complex cases which

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dominate most of the hospital case mix, that I think it's going to be a long ways before we get a good handle on that.

MR. HYMAN: Just so I'm clear, then, when you use quality, you mean, I guess what I would call reputation?

MR. TOWN: Yeah.

MR. BURGESS: Let me just add one other point on that, to just drive it down to the consumer even more clearly. Part of the problem is that if your goal is to look at patient flows and patient choices and what patients reveal preference about what they want, one of the problems is that we tend to measure quality and that's because the demand for measuring quality has come at aggregated purchaser health plan levels, so we design our quality measures focused with that. And just a simple example, think about a patient who as a very sick patient with diabetes and CHF and a whole host of conditions. What they really care about in going to a hospital is they want to go to a hospital that is going to be able to treat a really sick patient. They don't really care about some average level of quality risk adjusted for all the things that that patient has. They don't want that stuff taken out. They want to know who is going to be able to treat me,

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who is really sick.

And we don't organize our data in that way, as a health system, yet. I think we're heading in that direction, but we don't have that yet. So, I agree with Bob, too, that if going in that direction, if you're going to do that, we want to try to just set up the data in that way.

MR. HURLEY: I was just going to say, to appreciate just what a swamp this is, really, to follow the issue, take a look at what happened in California just about a year ago when the first of the tiered networks were rolled out. Blue Cross/Blue Shield was first out and Pacific Air and Blue Cross have them all now. It's extraordinary after all the years of effort that has gone into measuring quality and reporting systems and report cards, as soon as anything was done to even attempt to differentiate only on cost. The plans were just clobbered with this argument that you have to have quality information, and then they were clobbered further with the fact of the inadequacy of the quality of information.

So, it's a year later, the metrics that are for quality are things like, are you reporting to Leapfrog your levels of utilization for certain high volume services, or are you completing the satisfaction survey

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that might produce the results that then could be used for differentiation in order to qualify you for the higher tier. It's really extraordinary just how once we attempt to put our money where our mouth is on quality, how quickly people retreat from that. It's very disturbing.

MR. BURGESS: Just to make a point, that's a purchaser group. So, it's the question that you have a purchaser group is the one who wants it in that form and that's what they want to know. So, that's what they're asking for. So, that, again, my point is that that's not really a focus to the patients, it's focused at what the purchaser group wants to know.

MR. HYMAN: Scott? I guess I've got one or two more. This is for Bob Hurley, you said when we were talking about integration that there's often a conflict between serving institutional or community needs, or maybe it's just how you express the goals. I mean, I thought that was interesting, because community needs is itself, at least from an agency perspective, a peculiar way to articulate what you're about, is consumer preference as opposed to community needs would be the way that I think the agencies would think about this.

So, I guess the question that I have, and maybe

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this is just is health care special question in yet another guise, is why is it that it's framed in terms of community needs? Is that simply a cultural phenomena within hospital administrator training, and how frequently is it sort of do consumer preferences get even mentioned?

MR. HURLEY: I think that's a really good question, because I do think that there are -- and again, I'm going to be cynical about this or skeptical about this, but I think there are hospital executives who believe that, in fact, they are expressing community needs when they're talking about broader issues that go beyond their own individual instances. But the reason why I was using that phrase earlier was partly to kind of emphasize the point that I was raising about the kind of contemporary efforts at vertical integration that we're observing in several of our markets are really preemptive to keep the full-service hospital from being unbundled by these entrepreneurial spasms, if you will, in the market.

And, you know, again, you can argue whether or not you think that the hospital, and you may have said this earlier, one or both of them talked to us about what is the hospital and what's the kind of efficient boundaries or the appropriate boundaries

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for thinking about what constitutes this. But I think we have, you know, a significant challenge today in terms of establishing where are those boundaries going to be drawn as we see the unbundling occurring and the centrifugal forces that are pulling these services off from the institution and the degree to which individual physicians or groups of physicians' interest run counter to the maintenance of the full-service institution.

Now, whether the institution is better articulating community needs, I probably would bank a little more on them than I would on the group of cardiovascular surgeons who have got to have the Medcath facility in the suburbs. I think that's the kind of issues that we need in community -- it seems to me in communities today, we have a gap in terms of identifying who are the statesmen who talk about community needs and can articulate community needs, in the absence of any other kind of forums to be able to achieve that.

Certainly it's fallacious to think that the every hospital administrator who dons the mantel of speaking for community needs should be believed, but I think there are some transcending issues that the institution that the institutional history and heritage

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of the hospital still commands that, you know, in the center of the health care universe.

MR. BURNS: Yeah, I agree totally with that. That's one of the key undebated issues is the validity of these niche firms coming in and stripping these things off from hospitals. And how hospitals are responding to that also needs to be addressed. There ought to be some public discussion of that and more research on these things.

I know that Medcath has released its second report on how well their hospitals are doing in terms of quality and efficiency, but that needs to be, you know, analyzed in the wider scope of things. But clearly what the providers are doing is what Bob's saying. They're setting up their own, quote "Centers of excellence," unquote to retain physicians so that they don't bolt from Medcath.

MR. HYMAN: I'll just ask whether anybody wants to say anything else? No? Okay. Well, I'm pleased to announce that we are not only finishing ahead of time, but we have addressed the key issue already, which was single specialty hospitals we did two weeks ago. So, we're just slightly ahead of our time as the ad likes to say. And can you join me in a round of applause for our panelists.

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(Applause.)

(Whereupon, at 5:00 p.m., the workshop was concluded.)

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C E R T I F I C A T E O F R E P O R T E R

DOCKET/FILE NUMBER: P022106
WORKSHOP TITLE: HEALTH CARE AND COMPETITION LAW POLICY
HEARING DATE: APRIL 9, 2003

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

DATED: 4/9/03

Sally Jo Bowling

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

Sara J. Vance

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