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1 FEDERAL TRADE COMMISSION

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

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3 MS. MATHIAS: We're going to start on time so that
4 we can also finish on time. It's about 9:15. Welcome to
5 today's session of the FTC/DOJ Health Care Competition in Law
6 and Policy hearings that we're having. Today, I assume you
7 all know that we're going to be looking at single-specialty
8 hospitals and seeing various issues that have arisen in the
9 emerging single-specialty hospitals.
10 We aim to end today at about -- or end this
11 morning's session at 12:15, and then we'll reconvene at 2:00,
12 so that hopefully everybody will have a chance to get lunch
13 and then come back and watch for this afternoon's discussion,
14 which is hospital contracting practices.
15 As I'm sure everyone here is aware, the emergence
16 of single-specialty hospitals has been going on for a while,
17 but seems to have taken new interest. A lot of people are
18 paying attention to it. And, you know, we are interested in
19 seeing the various issues that have arisen, spend some time
20 discussing those issues, and listen to voices that are
21 involved in it. Some of the things that we were interested
22 in hearing about today are some of the factors that have led
23 to the unbundling, what has been the effects of this, have we
24 increased competition, have we had a quality increase or
25 decrease? There is also a question of access to various

1 consumers and patients that needs to be addressed. And we
2 will consider whether the development of single-specialty
3 hospitals like cardiac and cardiology is different than
4 single-specialty hospitals such as children's hospitals and
5 psychiatric hospitals.
6 I am extremely grateful to the panel for spending
7 time to get here, to prepare before you came, and we look
8 forward to listening to your wisdom throughout this morning.
9 We have a biography handout out at the table. We like to
10 spend more time talking about the issues than introducing
11 people, so unfortunately I'm going to give everybody a very
12 short introduction, but please pick out one of the bio
13 handouts so that you can get more information about the
14 eminent qualities of our various panelists.
15 I'm going to give a quick introduction, then we
16 will move -- what will happen is we'll allow Cara Lesser, who
17 is a Senior Health Researcher and Director of the Site Visits
18 at the Center for Setting Health System Change. The mission
19 of that entity is to analyze the U.S. health system, see how
20 it's changing, assess the implication of change for
21 consumers. We'll give Cara about 20 minutes to speak. She
22 has slides and David will help her advance the slides.
23 After that, each panelist gets seven to 10 minutes
24 to speak, and we'll start with Ted Frech, who is a professor
25 at the University of California, Santa Barbara, and adjunct

1 professor at the American Enterprise Institute.
2 Next, we'll move to George Lynn, who is the
3 President and CEO of Atlantic Care, and on the Board of
4 Trustees for the American Hospital Association. Mr. Eddie
5 Alexander is -- do I have my order right -- I do --
6 unfortunately he is not in the bio handout, because we had a
7 substitution at the last minute. We're very happy that he's
8 here; he is the President and CEO for the Surgical Alliance
9 Corporation.
10 And next is David Morehead, he's Senior Vice
11 President for Medical Affairs and Chief Medical Officer for
12 OhioHealth. Following David, we have John Rex-Waller, who's
13 the Chairman, President and CEO of the National Surgical
14 Hospitals.
15 After John, we have Dan Muholland, who's a Senior
16 Partner at Horty, Springer & Mattern. And to conclude at
17 that first conclusion is Dennis Kelly, who is the Executive
18 Vice President of Development and Government Relations for
19 MedCath. We will take a break after everybody's had a chance
20 to give their seven to 10-minute presentation, and then we'll
21 reconvene after 10 minutes and have a moderated roundtable.
22 And I forgot to mention that I am joined here by
23 Bill Berlin, who's with the Department of Justice. He is one
24 of my cohorts in pulling all this together. We couldn't do
25 it singly. We need both agencies, and I think it gives us an

1 opportunity to explore these issues fully and hopefully
2 address it in a manner -- in a unified manner later on.
3 Anyway, with no further ado, I'd like to introduce
4 Cara and have her begin.
5 MS. LESSER: Thanks. Well, good morning. I'll
6 get started a little while we're waiting for the slides to
7 come up, if that's okay. David's been kind enough to help me
8 out, since I'm about eight and a half months pregnant; I'd
9 prefer to be seated for this presentation and not to have too
10 much drama at these hearings today.
11 But I'm here this morning to share with you some
12 of the work we've been doing in local health care markets
13 across the country, tracking how health systems are changing.
14 And one of our key areas of interest has been specialty
15 hospitals and the development of these facilities and their
16 effects on market dynamics. So, we were really pleased to be
17 invited here today to share some of that work.
18 Just briefly, Sarah gave a very nice brief
19 overview of the Center for Studying Health System Change. I
20 just wanted to reinforce, we're an independent, objective
21 research organization founded by the Robert Wood-Johnson
22 Foundation in 1995, just after the demise of Clinton health
23 reform efforts, and as it became clear that the country was
24 really embarking on some very significant market-based
25 changes. And the Foundation was interested in tracking those

1 changes and providing information to policymakers about the
2 implications moving forward. And website is there for those
3 of you not familiar with us to check out some of the work
4 we've been doing over the past several years.
5 At the core of our work is the community tracking
6 study, which is an independent research effort to track
7 health system change and its effects. It's a longitudinal
8 study and it's been ongoing since 1996. As the name implies,
9 the study has a community focus, based on the notion that
10 ultimately all health care is local. We define our
11 communities based on MSAs, so we have a consistent measure of
12 a geographic market over time, and that's what we're really
13 tracking in each of our rounds.
14 We focused on 60 communities that were selected
15 randomly to be nationally representative, and this gives our
16 study a unique advantage of being able to identify changes at
17 the local level but then aggregating those findings up to
18 speak to national trends. We have multiple ways that we
19 collect data. We conduct surveys of households and
20 physicians, and we also conduct site visits every two years
21 in 12 communities of the 60 that were actually also randomly
22 selected from the 60. These are communities with a
23 population of 200,000 or more, so they're large metropolitan
24 areas and representative of the areas where the majority of
25 the population lives.

1 In our site visits, we interview leaders of local
2 health systems, health plans, hospitals, hospital systems,
3 and physician organizations. We speak with representatives
4 of major local employers, and state and local policymakers.
5 We really make an effort to speak with the broad range of
6 stakeholders in each of these markets.
7 This map shows the 60 study sites and the subset
8 of 12 where we conduct our site visits. You can see the
9 sample is geographically diverse. The communities vary in
10 size and health system characteristics. We have large
11 metropolitan areas, like Boston, Orange County, Miami, places
12 with, you know, large population and also extensive
13 experience with managed care, and then other smaller
14 communities, like Little Rock and Greenville, South Carolina
15 that have less experience with managed care. So, it’s really
16 a broad range.
17 Today, I’m going to draw on early findings from
18 our most recent site visits, which are actually still in the
19 field right now. They were started in September 2002 and
20 will be running through May 2003. And, as I said, I want to
21 talk about, you know, what we’re seeing with respect to
22 specialty hospitals across the country.
23 I’m just going to start with a brief overview of
24 the prevalence and key characteristics, and then describe the
25 market context for this phenomenon from our perspective,

1 focusing on the various forces that are driving specialty
2 hospital growth and the effect it's having on market
3 dynamics. And then against that backdrop, I will just talk a
4 little bit about the implications of specialty hospital
5 growth for cost, quality and access to care.
6 Not news to anyone in this room, I'm sure that
7 we've seen rapid growth of specialty hospitals, really over
8 the past seven years that we've been tracking markets, but
9 especially in the past few years. In the 12 markets that we
10 tracked, there have been 11 new free-standing facilities that
11 have come online during this time. Some of them are
12 independent facilities; and some of them are joint ventures
13 between community hospitals and local physicians. In
14 addition, there are a number of hospitals within hospitals
15 that the general acute care hospitals have set up as
16 designated units that provide certain specialty services.
17 So, while there's a great deal of attention to specialty
18 hospitals started by national entrepreneurial firms like
19 MedCath and National Surgical Hospitals, we're actually
20 seeing the general acute care hospitals in local markets as
21 very active players in this arena, as well.
22 Key characteristic of the speciality hospitals is
23 physician ownership, and this is something that really
24 distinguishes the speciality hospitals of today from the
25 traditional acute care hospitals and from some of the

1 children's hospitals and other single-specialty hospitals
2 that we've seen in the past.
3 There's a great deal of consistency in the
4 services that these hospitals are focusing on. Cardiac care
5 and orthopedics are by far the most common. We're also
6 seeing a smattering of facilities focusing on general
7 surgery. And one place where there's a lot of variation is
8 in the scope of emergency services provided. Some have full-
9 service emergency departments; others have no emergency
10 services and rely on agreements with local hospitals for
11 transfers; or in cases where the specialty facility is
12 affiliated with part of a larger system, local system,
13 they'll have an agreement as part of that system.
14 There are a number of market developments that are
15 contributing to the growth of specialty hospitals. First is
16 the retreat from totally managed care and the associated
17 utilization controls and expectations about selective
18 provider networks. In the absence of these constraints,
19 there has been a shift in provider strategy from managing
20 hospital services as a cost center toward an emphasis on
21 promoting key services as revenue enhancers. And, in fact,
22 many hospital administrators are quick to point out that
23 there are certain procedures and services and service lines
24 that are clear winners for them because reimbursement is so
25 much greater for those services. And that's often both under

1 Medicare and private payors' reimbursement schemes.
2 Cardiac and orthopedic procedures, no surprise,
3 are commonly noted and that's why, you know, a major reason
4 why we're seeing a lot of the growth in this area. Actually,
5 in our most recent visits there was a hospital CFO who told
6 us that his entire -- the institution's entire 2.5 percent
7 margin, which isn't a huge margin, but that entire margin was
8 based on cardiac services alone.
9 A third major market development that's
10 contributing to the growth of specialty hospitals is just the
11 squeeze on physician income. And this is really as
12 physicians are facing declining professional fees, they're
13 looking to capture at least a portion of the facility fees
14 that can help them to supplement their incomes. Plus,
15 physicians are -- this income pressure has left them really
16 frustrated over hospital control over management decisions
17 and investment decisions that affect their productivity and
18 is really pushing them to look to have a greater say in those
19 decisions.
20 And, finally, just the growth of entrepreneurial
21 firms such as MedCath and National Surgical Hospitals
22 certainly has helped to spur the development of these
23 facilities.
24 Okay, so as I mentioned, the services that
25 specialty hospitals tend to target are a key source of

1 revenue for general acute care hospitals and consequently the
2 growth of these facilities worries them a great deal. And
3 there are three main ways that we've seen the general
4 community hospitals respond.
5 First is the kind of preemptive strike strategy
6 where the hospital establishes its own specialty facility in
7 an effort to ward off the establishment of the competing
8 facility in the market. Sometimes this occurs in direct
9 response to talks between a national firm and local
10 physicians; and in other cases hospitals appear to be
11 pursuing this strategy, just on their own, before something
12 like that happens. Typically, these arrangements will offer
13 physicians some attractive features, like better O/R hours,
14 you know, access to new, better technology, but it generally
15 doesn't involve physician investment, so it really remains a
16 hospital-owned entity.
17 The second strategy is to joint venture with local
18 physicians. This is the "if you can't beat them, join them"
19 strategy. And it's really what we've seen hospitals turn to
20 more, as there's a direct threat from potential competitors
21 in their market. And this is really a way to just stave off
22 the total loss of business for the general acute care
23 hospital. And one hospital executive said it pretty
24 succinctly, I thought, which was, "a half a loaf of bread is
25 better than no loaf of bread at all." So, this is really, I

1 think, for the most part viewed as a second-best strategy for
2 hospitals, but it's something we're seeing a lot of in our
3 markets.
4 Finally, there are some hospitals that have taken
5 a philosophical stance against specialty hospitals and have
6 refused to consider joint ventures as an option. These
7 hospitals instead have focused on really fighting physicians
8 who are the organizations that try to establish competing
9 facilities. One strategy has been to use economic
10 credentialing, which is really essentially denying admitting
11 privileges to physicians who have an ownership stake in a
12 competing facility. Or some hospitals also have informally
13 discouraged plans from contracting with competing facilities
14 in their markets. And this is something we've heard alleged
15 in one market where a heart hospital that was opened a few
16 years ago still has been unable to obtain any commercial
17 contracts in that market. They're relying only on Medicare
18 at this point.
19 So, in many cases these actions have been
20 challenged in courts in a number of communities, and there
21 are questions obviously about the legality of these actions.
22 From the perspective of people concerned about
23 competition policy, the growth of specialty hospitals and the
24 competitive response they're evoking from traditional acute
25 care hospitals raises a number of questions around cost,

1 quality and access. On the one hand, specialty hospitals are
2 based on the premise that practice makes perfect and that
3 focused factories can promise higher quality and lower costs
4 for consumers. But the ability to achieve this is really
5 dependent on a number of factors, including their effects on
6 per-case costs and quality, the relationship between supply
7 and demand, prices for these services, their effects on
8 patient mix and the distribution of volume across the market
9 and their effects on access to other less profitable
10 services. And I'm just going to quickly go into a little bit
11 more detail on each of those.
12 The "practice makes perfect" argument assumes that
13 specialty hospitals will be able to generate lower per-case
14 costs and higher quality by becoming more expert and
15 efficient at the services they provide. Physicians and
16 health care executives who are involved in establishing these
17 facilities argue that this -- the speciality facility is like
18 a blank slate and it gives them the opportunity to redesign
19 the care delivery process in a way to be more effective and
20 efficient, especially since it's targeted to a narrower set
21 of services.
22 They also allow the opportunity to recruit nurses
23 and technical staff who can become more expert at this care.
24 And it's really viewed as an opportunity to make improvements
25 in the care delivery process. In addition, simply by

1 concentrating more cases in a particular facility, specialty
2 hospitals may help to lower per-case costs and boost quality.
3 Certainly, the health services research literature that is
4 established literature on the volume outcomes relationship
5 that says that the more volume you have concentrated at a
6 particular facility, the more likely you'll have better
7 outcomes. But these effects really are -- the effects on
8 patient volume remain to be seen, because if you have the
9 growth of more facilities and you spread volume across a
10 greater number of facilities, there actually could be
11 negative effects, both on quality and costs, and the per-case
12 cost.
13 This leads to the question of the effects of
14 specialty hospitals on supply and demand on the market. One
15 important question is whether the growth of specialty
16 facilities, and again, this is both on the part of
17 independent facilities and the activities of traditional
18 acute care hospitals, whether this is creating more capacity
19 than there is demand for. This, obviously, is a pretty
20 tricky question, especially given the recent capacity
21 constraints that have emerged in markets over the past few
22 years. And this is, you know, really for the first time in
23 decades that we've seen capacity constraints in markets
24 again.
25 On the one hand, there are a number of forces that

1 are driving increased demand today. There's the aging of the
2 population, population growth, and just higher functioning
3 and higher quality of life expectations associated with the
4 baby boom. But on the other hand, we have new technology,
5 such as drug-eluting stents that can have a sharp downward
6 effect on demand. And demand, especially for specific
7 procedures that some of these facilities are targeting. So,
8 for these reasons, the demand curve is very difficult to
9 predict in health care, and it's a risky proposition, because
10 unlike in other markets, excess capacity is rarely taken out
11 of health care markets and can play a major role in
12 contributing to underlying health care costs.
13 Another area of concern for specialty hospitals is
14 the potential for supply-induced demand, or demand that's
15 generated due to the presence of these facilities. Again,
16 the health services research that has been done over the past
17 decades really has shown that this issue of supply-induced
18 demand is particularly problematic when physicians are owners
19 and when there is excess capacity. So, the implication here
20 is that specialty hospitals may actually create additional
21 demand in driving appropriate utilization that's actually
22 cost-increasing and has negative effects on quality.
23 Of course, the critical question is what specialty
24 hospitals do in terms of price, and theoretically, the more
25 competitors, the more capacity should spur greater price

1 competition. But, again, the way that the specialty hospital
2 growth is playing out in markets, there may be some real
3 constraints to this phenomenon. In many cases, when the
4 general acute care hospital in a community, either partially
5 or fully owns a specialty hospital, the rates for the
6 specialty hospital are negotiated as part of that larger
7 system. And the desire for the system to maintain sufficient
8 profits from these services to be able to cross-subsidize
9 their less profitable services, such as emergency care and
10 trauma, depresses the incentive to compete on price.
11 That said, it's important to point out that even
12 if specialty hospitals don't do much to lower prices or
13 improve the per-case cost and quality, there still is ample
14 room for them to do well financially and be profitable if
15 they're able to attract a more favorable patient mix. And by
16 that, I mean patients with coverage that yields higher
17 reimbursement, so Medicare and private-pay patients as
18 opposed to Medicaid and the uninsured, patients with less
19 complex cases to treat and patients who need services that
20 are paid at higher rates. So, in that way, speciality
21 facilities certainly can be successful on their own terms,
22 but will not generate the broader societal gains in terms of
23 lower costs and better quality.
24 While specialty facilities may lead to improved
25 access for certain services and for certain patients, there

1 may be a cost from the broader system and societal
2 perspective also in terms of the ability of general hospitals
3 to maintain the cross-subsidies necessary to fund other less
4 profitable services. And, again, this is coming from not
5 only the pressure from the national firms creating these
6 facilities but from the activities of the general acute care
7 hospitals themselves and really raises questions whether
8 those hospitals will be able to maintain the full array of
9 services that we really expect them to provide in
10 communities.
11 Obviously, as this range of services deteriorates
12 and to the extent that specialty facilities target patients
13 who bring higher reimbursement, this will likely have a
14 disproportionate effect on Medicaid beneficiaries and the
15 uninsured.
16 So, in conclusion, specialty hospitals and the
17 competition for these key specialty in-patient services are
18 playing a major role in shaping the competitive dynamic in
19 markets today. Although much of the discussion focuses on
20 the entrepreneurial firms versus the community hospital, our
21 research has really underscored that both types of players
22 are competing for this business and shaping the issues at
23 hand.
24 There are a number of questions about the effects
25 on cost, quality and access that obviously will be important

1 to monitor over time. There are no clear-cut answers to
2 these questions at this point, but I think that from our
3 research, it really again underscores that we need to think
4 about these within the context of the broader market
5 environment and the effects that they're having on
6 competition.
7 Just very briefly I wanted to close on some of the
8 policy options that are out there as ways to potentially
9 address these issues as we get a clearer sense of what the
10 implications are. One is to look at Medicare payment policy,
11 which many point to as a key driver in the payment
12 differential for some of these services. And this is
13 important because Medicare is -- many private payors use
14 Medicare payment as a benchmark, so changes in Medicare
15 payment potentially could have effects beyond just the
16 Medicare population alone.
17 The courts provide another forum for policy
18 influence over this activity. As I mentioned, there are a
19 number of cases pending at the moment, looking at the ways
20 that hospitals and physicians have responded to this activity
21 in their markets. And this again will likely have effects
22 beyond just the specific markets in which they're considering
23 these issues.
24 Another avenue is federal and state regulation of
25 these facilities. Some have proposed revisions to the Stark

1 rules, for example, that govern physician self-referral and
2 are looking to address these types of facilities
3 specifically. At the state level, there has been proposed
4 legislation looking at requirements around emergency services
5 and really just setting some parameters for these
6 organizations.
7 Finally, one other policy option to consider is
8 alternative approaches to funding critical services such as
9 emergency care, that don't rely on cross-subsidies. And this
10 is something that if we do find over time that specialty
11 hospitals are effective in providing higher quality and lower
12 cost care, but are undermining this source of revenue for
13 these other services, one strategy would be to look toward
14 other payment schemes to ensure that those services are
15 available in community health systems.
16 So, with that, I will wrap up.
17 MS. MATHIAS: Thank you very much.
18 (Applause).
19 MS. MATHIAS: Next, we'll move to Ted. You can
20 stand or sit. By the way, for all the panelists, we allow
21 you to choose whether you want to be up at the podium or
22 sitting down at the tables. I forgot to mention that Ted is
23 professor of economics. I think I just said professor.
24 PROF. FRECH: Thanks, Sarah. It would become
25 clear that I am professor of economics, because what I'm

1 going to talk about is the basic fundamental economics of the
2 single-specialty hospitals, sort of why do they exist? Most
3 of what I say would fit for any industry, but I'll focus on
4 hospitals.
5 And the first thing is diseconomies of scale and
6 scope. Hospitals are multi-product firms supplying thousands
7 of different services. And they have economies of scale.
8 Larger hospitals are more efficient, up to a fairly large
9 scale, and in my research, 200 beds or more. They also have
10 economies of scope, most of the time, that are benefits to
11 supplying lots of different services together. It's cheaper
12 that way. You can spread overhead over many different
13 services, say, MRI machines serve many different diagnoses;
14 scheduling and nurses; the same space can be used. So, the
15 scale and scope interact, so if you can have more of a scope
16 of output, you can also attain scale economies in some of
17 these services you might think of as kind of support
18 services.
19 From the consumer point of view, there are also
20 economies of scope. If you have or develop some condition
21 that was not expected in the hospital, it's very convenient
22 to have the services you need for that on that campus, and
23 not have to be shipped somewhere or have some specialist
24 shipped in.
25 Now, does this suggest that every hospital should

1 have 10,000 beds and every possible service? No. If it did,
2 you might -- there would be a problem. There are
3 diseconomies of scale and scope that eventually come in to
4 play. And hospitals can obviously be too large. Information
5 flows may be limited. There may be too many layers of
6 bureaucracy. The competition and coordination of different
7 resources for different parts of the hospital gets to be
8 difficult.
9 So, certain services may be more efficient in more
10 narrowly focused hospitals -- the focused factory idea. And
11 this may work especially well if you can take those services
12 out of several general hospitals and concentrate them on one
13 single specialty hospital. Now, at least one thing to note
14 in passing, that even what we call specialty hospitals still
15 provide at least hundreds and often thousands of services.
16 So, they're still multi-product firms, okay? They're just
17 not quite as big of a bundle of different products.
18 Okay, so diseconomies of scale and scope could be
19 one reason to carve-out a specialty and start a specialty
20 hospital. The second thing I want to talk about, and Cara
21 talked about this some in slightly different terminology, is
22 price discrimination by general hospitals. Hospital
23 competition at its best is quite imperfect. So, hospitals
24 have market power, and so they charge more for some prices
25 relative to other prices -- or some services relative to

1 other services. Or, in other words, some services are more
2 profitable than other services. This is price
3 discrimination.
4 Some types of surgery are reported to be high
5 profit. Well, as entry barriers decline and hospital markets
6 get more open and more competitive, what attracts entry are
7 the high profit services, the ones with the high prices that
8 are -- where the hospitals -- the general hospitals are
9 benefitting by the price discrimination. So, you would
10 expect entry to be in the most profitable lines. In fact, it
11 could easily be the case that no one could afford to enter
12 with a broad-based hospital, that it would have to be a
13 hospital focused on the high-priced, high-profit lines.
14 One thing to note is this could happen, you could
15 have entry, specialized entry, into the profitable lines,
16 even if there were no particular production advantages. It's
17 just that the less competitive lines, with the highest
18 prices, attract entry more.
19 Another reason why you get single-specialty
20 hospitals is price controls on physicians. Some physicians
21 have very strong reputations, or they are in specialties that
22 are scarce in their geographic area. These physicians could
23 charge very, very high fees in a fully open market and still
24 be busy. We don't observe this very much, because there's
25 price controls of two kinds. One is a formal governmental

1 price control on Medicare and Medicaid, Medicaid Fee for
2 Service anyway.
3 Then there’s also informal kind of price control
4 even in the private sector. Maybe you should call it quasi-
5 price control and not -- I’m not quite sure -- there isn’t
6 really a standard term for it. This is the social and
7 political and bureaucratic pressure not to charge too much
8 over the going rate. Even if you are in a very scarce
9 specialty or a very famous guy somewhere. This gets enforced
10 by insurers, you know, telling the consumers what’s the
11 reasonable rate and helping them sometimes if they get sued,
12 the courts being reluctant to enforce payment of very high
13 fees that are much higher than average fees.
14 So, this private sector version is softer than the
15 black-and-white rules of, say, Medicaid in California for a
16 fee-for-service or Medicare, but it still has the effect that
17 there are some of these physicians out there who, in effect,
18 are frustrated by these price controls. Well, in general,
19 suppliers facing price controls can get around them to some
20 extent by selling a complimentary service in the form of a
21 bundle. Well, physicians could do that by creating a single-
22 specialty hospital that they control and making some profit
23 on the hospital services in place of raising their fees,
24 which is kind of -- which they’re frustrated by the legal and
25 I’d say even the social system of medicine from doing.

1 Another reason, different reason, is the politics
2 and economics of competition for resources within a hospital.
3 Physicians compete for patients, of course, but they also
4 compete internally for hospital resources, time in the
5 operating room, and good times, not just some time; nursing
6 support; technician support; all kinds of resources they
7 compete for. Well, some physicians lose out in this
8 competition, and some specialties. And one way to deal with
9 that is to create a single-specialty hospital that you
10 control, and then you can decide yourself on how many
11 resources you should have.
12 The last general category I want to talk about is
13 starting a single-specialty hospital can be an excellent
14 competitive strategy for a general hospital, especially for a
15 general hospital that's weak in that specialty, and
16 especially in markets with not so many hospitals. So, for
17 example, suppose there are two competing hospitals, and I
18 actually have a town in mind for this, but for various
19 reasons, I can't say what town it is. There are two
20 competing hospitals. Hospital A is very strong in
21 cardiology; Hospital B is kind of weak in it. Hospital B may
22 start a single-specialty cardiology hospital to attract
23 cardiologists and business from Hospital A and thereby
24 neutralize Hospital A's advantage.
25 This can work even if the hospital that helps the

1 founding of this new specialty hospital in cardiology has no
2 control over it. It obviously works better if they control
3 it, but they don't have to for this to work as a competitive
4 strategy.
5 So, just in conclusion, there are several economic
6 factors that give rise to the creation of specialty
7 hospitals, ranging from production economies to competitive
8 strategies by existing general hospitals. It's very hard to
9 say a priori which ones of these are more powerful, and I'll
10 be fascinated to hear from the rest of the panel about these
11 things.
12 (Applause).
13 MS. MATHIAS: Thank you.
14 MR. LYNN: Good morning, everyone. My name is
15 George Lynn. I'm President and Chief Executive Officer of
16 Atlantic Care, an integrated health care network based in
17 Atlantic City, New Jersey. Atlantic Care provides a
18 comprehensive range of health care services and serves the
19 southeastern region of New Jersey. I also serve on the board
20 of the American Hospital Association and I'm here today on
21 behalf of the AHA and its nearly 5,000 member hospitals,
22 health systems and other providers of care.
23 The delivery of health care in America is changing
24 rapidly. This change is fueled by many factors, including
25 the development of new care settings. In the midst of this

1 change, one thing has remained constant. Communities across
2 America rely on hospitals to provide them access to basic
3 health care services. They look to the mission of hospitals
4 and the physicians who serve with them to provide care to all
5 people, including those who are uninsured or under-insured.
6 Community hospitals serve as the medical safety net for those
7 in need.
8 We appreciate the opportunity to participate on
9 this panel and address the effect of specialty-care providers
10 on meeting the health care needs of communities. Specialty-
11 care providers, those that focus on a specific set of medical
12 services, condition or populations, aren't new, but the
13 nature and pace of their growth is new. Historically, they
14 were children's hospitals or psych. hospitals; now they
15 include heart hospitals, cancer hospitals, ambulatory surgery
16 centers, dialysis clinics, pain centers, imaging centers,
17 mammography centers and a host of other narrowly focused
18 providers generally owned, at least in part, by the
19 physicians who refer patients to them.
20 We are very concerned that growth of specialty
21 care providers, if left solely to market forces, will
22 undermine access to health care services for communities all
23 across the country. Let me explain why.
24 First, specialty-care providers often don't serve
25 the broader community. The rapid growth of specialty care

1 providers threatens community access to basic health services
2 and jeopardizes patient safety and quality of care. The
3 trend among these providers is to carve-out the more
4 profitable services and to serve the more profitable
5 patients. They leave the community hospital to provide
6 unprofitable services, such as trauma, and to care for all,
7 regardless of their ability to pay.
8 Specialty care providers have little or no
9 obligations under the Emergency Medical Treatment and Labor
10 Act, EMTALA, either because they operate on an ambulatory
11 basis or because they don't have to have emergency
12 departments. Specialty-care providers rely on the emergency
13 capacity of local community hospitals. Many specialty-care
14 providers do not participate in Medicare or Medicaid, or
15 limit their participation when they do, and then many provide
16 very little uncompensated care. These business decisions
17 allow some specialty-care providers to produce service less
18 expensively, while often being paid the same or more than
19 community hospitals that carry the social obligations to
20 provide care to all 24 hours a day, seven days a week, 365
21 days a year.
22 Secondly, specialty-care providers are
23 undercutting the ability of community hospitals to meet the
24 needs of the broader community. As profitable services are
25 drawn away from general community hospitals, it becomes more

1 difficult to support services needed by the community that
2 are unprofitable: trauma centers, burn units and emergency
3 departments are not self-supporting. Caring for the
4 uninsured, Medicaid patients and others who have limited
5 coverage can only be accomplished if the hospital can rely on
6 revenues from profitable services. If these profitable
7 services and more profitable patients are removed from the
8 community hospital, its ability to continue meeting the needs
9 of the entire community deteriorates. The result? The
10 community loses access to specific services or ultimately to
11 all the hospital services as the general hospital
12 deteriorates or closes.
13 Communities are also losing access to specialty
14 physicians because of the growth of specialty providers. The
15 consequences for emergency patients can be life-threatening.
16 Many communities are already experiencing this problem as the
17 hospital emergency departments go on diversion for all or
18 certain types of cases. A primary reason, lack of specialty
19 physicians willing to serve on call and treat patients in
20 need.
21 At the same time, specialty providers are drawing
22 profitable services and specialty physicians away from the
23 community hospital. They expect those same hospitals to be
24 their backup. Consider the safety of a patient admitted to a
25 specialty hospital for a routine surgical procedure who then

1 develops complications beyond the capacity of that specialty.
2 This surgical patient has to be transferred to a general
3 acute care hospital for needed care. Or consider the nearby
4 resident out for a jog who experiences chest pain outside a
5 specialty hospital, goes inside to seek assistance and is
6 told to call 911.
7 Specialty providers are increasingly owned by the
8 same physicians who make decisions about when and where
9 patients should receive care. Specialty physicians are
10 making decisions about care for their patients that will also
11 have an effect on the physician's personal financial
12 interest. Even in a competitive environment, caring for sick
13 people transcends to simple buy/seller relationship.
14 Patients need to be able to trust that decisions about their
15 care will be made on the basis of what is in the best
16 interest of the patient, not the provider. Left to market
17 forces alone, the incentives in a competitive market may
18 leave some providers to make business decisions that raise
19 issues for patients and the communities they serve.
20 In closing, communities will not be well served if
21 the growth of specialty providers is viewed solely from the
22 perspective of bringing more entrants into the marketplace.
23 Their growth must also be looked at from the perspective of
24 meeting the health care needs of the community. In that
25 context, these providers do not add a satisfactory

1 alternative. Instead, they withdraw resources for a select,
2 desirable population and leave to others the responsibility
3 for meeting the needs of the entire community, while
4 compromising their ability to do so. The local hospital is
5 part of the essential fabric of a community. For the
6 antitrust agencies to truly assess the effect of specialty-
7 care providers, they need to take into account their effect
8 on the medical safety net for a community and whether the
9 needs of the entire community are served by their presence
10 and growth.
11 Thank you.
12 (Applause).
13 MR. ALEXANDER: Good morning. I am Eddie
14 Alexander, the Founder, President and Chief Executive Officer
15 of Surgical Alliance Corporation. It's my privilege to be
16 with you this morning and to share with you my thoughts
17 regarding the changing face of health care delivery and
18 financing. And I'm pleased to offer advice on today's
19 subject, single-specialty hospitals.
20 From our headquarters in Nashville, Tennessee,
21 Surgical Alliance partners with physicians to develop,
22 design, manage and operate specialty surgical facilities
23 focused on the unique needs of patients with orthopedic,
24 neurosurgical problems and is designed to enable physicians,
25 nurses and other medical personnel to deliver the best

1 coordinated patient-focused care.
2 I had actually hoped to be joined today by Dr.
3 Adolf Lombardi, an orthopedic surgeon from Columbus, Ohio,
4 with whom I work closely, so you could hear firsthand his
5 rationale and support as a practicing physician for an
6 alternative orthopedic surgical hospital model.
7 Unfortunately, Dr. Lombardi's practice and teaching
8 obligations did not allow for him to be here today.
9 Working together with our physician partners, who,
10 like Dr. Lombardi, regularly face the challenges of our
11 current system of delivering patient services, we have
12 undertaken to develop a new orthopedic, neurosurgical
13 specialty hospital that we believe will enhance patient care
14 and also stimulate competition in the central Ohio health
15 care marketplace.
16 Specialty hospitals are emerging throughout the
17 United States, establishing new models for success in patient
18 treatment. What motivates the evolution to specialized
19 ambulatory surgical centers and specialty surgical hospitals?
20 It is a common-sense, intelligent response to a mature health
21 care delivery system and industry gripped by inefficiencies
22 and to health care spending being out of control. Health
23 care spending represents over 13 percent of our gross
24 domestic product, or approximately $1.3 trillion. Over a
25 third of those costs are tied to hospitalization. While

1 costs have soared, quality of care in the big, traditional
2 hospitals has deteriorated. Simply put, the current hospital
3 model is in many respects outdated, inefficient and suffering
4 in quality. Specialized facilities are a natural progression
5 and are a recognition that the system needs to be tweaked,
6 perhaps overhauled, to achieve lower costs, higher patient
7 satisfaction and improved outcomes.
8 Research data on specialty facilities does
9 demonstrate superior results, lower costs and sufficient
10 efficiencies absent from our current system. Medicine itself
11 continues to witness a tremendous explosion in knowledge and
12 information sharing. Rapid and exciting technological
13 advancements have resulted in ever-increasing sub-
14 specialization within the various medical specialties. The
15 shared desire to harness this knowledge and to focus their
16 energies to enhance patient care served as the catalyst for
17 Dr. Lombardi and his colleagues to pursue the development of
18 a new specialty hospital in suburban Columbus, Ohio,
19 dedicated to musculoskeletal and neurological disorders, the
20 New Albany Surgical Hospital.
21 Over 30 leading orthopedic physicians have joined
22 together with Surgical Alliance to develop this specialty
23 hospital, which will encompass orthopedic surgery, physical
24 therapy and rehabilitation, neurosurgery, neurology, spine
25 surgery, pain management, emergency medicine and internal

1 medicine. Our shared purpose is to establish a premier
2 Central Ohio facility dedicated to offering the patient the
3 latest in technological advancements in the field of
4 orthopedic surgery. Our primary mission is to provide our
5 patients with the best orthopedic care in the entire world.
6 Further, we share a common commitment to continue to be a
7 positive asset to the community in part by doing our fair
8 share in treating those who cannot pay, sometimes referred to
9 as charity care, and by devoting significant resources to the
10 training of new professionals and to the research and
11 development of better care and treatment for musculoskeletal
12 disease.
13 What prompted this undertaking? It was not a
14 decision made lightly. Our physician partners have
15 established well respected practices based in Columbus, with
16 patients from across Ohio and every state surrounding Ohio.
17 Quite simply, we and they believe that the New Albany
18 Surgical Hospital, or NASH, set to open later this year, will
19 allow our physician partners to provide better, more timely
20 patient care, at a reasonable price in a more patient-focused
21 and friendly environment. In essence, we want to provide our
22 patients with the best care possible in a cost-effective
23 manner.
24 For hospital services, the geographic distances
25 that patients must travel tend to define a market, and be

1 barriers to competition. Our new hospital will be located in
2 New Albany, a suburb of Columbus, Ohio. The local health
3 care marketplace in Greater Columbus is dominated by three
4 major hospital systems: OhioHealth Corporation, Mount Carmel
5 Health System and Ohio State University Medical Center. Our
6 proposed venture has met with stiff and coordinated
7 resistance from these large, not-for-profit hospital systems
8 that control all eight general hospitals and 100 percent of
9 the in-patient hospital beds for adults in the Columbus
10 market.
11 Their efforts to maintain the status quo are
12 driven not by quality, cost efficiency or the desire to
13 preserve the delivery of charity care to the community, but
14 rather by the fear of having to compete, of having to look
15 within their respective institutions to improve efficiencies
16 and to enhance the timely delivery of patient care.
17 The operating rooms at in-patient hospitals in
18 Columbus are at capacity. Physicians try to block or reserve
19 operating room time. However, if the physicians are unable
20 to negotiate adequate time, then they must simply wait on
21 standby for an operating room to become available. Recently,
22 two of our physicians have had waits of over 30 days in the
23 Columbus market before gaining operating room time, certainly
24 not an optimal situation for a patient needing orthopedic
25 surgery.

1 Given the relative small size of NASH, eight
2 operating rooms and 42 beds, our intention and expectation
3 has been that much of the work of our physician partners
4 would continue, as always, at their traditional general
5 hospital facilities. NASH cannot accommodate, nor was it
6 designed to accommodate, all of the operating room time and
7 staffing needs of our many physician partners.
8 When completed later this year, NASH will account
9 for less than 1 percent of the hospital beds in the Columbus
10 area. Our initiative will certainly help the problems that
11 our practicing physicians now face of insufficient operating
12 room time options, but it is not really a realistic threat to
13 the general hospitals.
14 NASH is under construction and is scheduled to
15 open this November. In an effort to forestall competition,
16 two of the hospital systems in Columbus, OhioHealth and Mount
17 Carmel, recently passed resolutions to revoke existing
18 privileges of medical staff members and to withhold new
19 privileges solely on the basis of a physician's investment
20 interest in NASH or any competing specialty hospital.
21 Dr. Lombardi has dealt with this prohibition
22 firsthand. Although Dr. Lombardi has performed virtually all
23 of his in-patient surgeries over the last few years at an
24 OhioHealth hospital, he has been put on notice that
25 OhioHealth will revoke his privileges at that hospital after

1 NASH opens, solely due to his investment in NASH.
2 In anticipation of this heavy-handed reaction, Dr.
3 Lombardi applied for privileges at a Mount Carmel hospital,
4 and despite his unquestioned and impeccable credentials as a
5 hip and knee replacement surgeon, his application was
6 rejected solely due to his investment in NASH. As a result,
7 Dr. Lombardi faces the prospect of being unable to serve his
8 patients in a timely manner after NASH opens because he may
9 not have access to sufficient operating room time.
10 These unfair actions stifle competition by
11 punishing physicians who invest in potential competitors
12 through the denial of staff privileges and access to scarce
13 operating room time at the not-for-profit hospitals. This
14 process of economic credentialing, the use of economic
15 criteria, unrelated to quality of care or professional
16 competency, in determining an individual's qualifications for
17 initial or continuing privileges is opposed by the AMA, which
18 urges that physician credentialing and privileging be
19 assessed on the basis of their education, training,
20 experience and documented competence.
21 Economic credentialing limits patient choice and
22 access to care and it eliminates referrals to hospitals or
23 other out-patient facilities that may be more clinically
24 appropriate, cost-effective or convenient for patients.
25 Requiring a physician to limit his or her referrals to one or

1 a short list of accepted facilities serves only the interest
2 of the accepted hospital and rarely is it in the best
3 interest of the patients. Not only is this activity anti-
4 competitive, vis-a-vis the affected physician, but it also
5 has a chilling anti-competitive effect on the entire
6 marketplace for the delivery of those medical services.
7 Not-for-profit hospitals or NFPs account for about
8 85 percent of all hospitals in the U.S. and 100 percent of
9 the hospitals in Columbus. They hold a great advantage over
10 specialty hospitals, given their existing market domination.
11 Despite their complaints of unfair competition, these large
12 hospitals have more capital, more resources and the leverage
13 of possessing dominant market position.
14 In addition, they are accorded, in exchange for
15 certain unprofitable community services, a wide array of
16 special treatment from the legislature and the regulatory
17 community. Not the least of these preferences is the fact
18 that the hospitals, not-for-profit hospitals, pay no state or
19 federal income taxes or local property taxes. In many
20 states, the hospitals have also been protected from
21 competition through certificate of need programs, yet another
22 barrier to new market entrance.
23 Ohio's certificate of need program for hospital
24 expansions was eliminated by the Ohio General Assembly in
25 1995. State Senator Lynn Watchman, the Chairman of the Ohio

1 Senate's Health, Human Services and Aging Committee, observed
2 recently that this deregulation is just now beginning to
3 yield good fruit with a more competitive landscape in Ohio.
4 Specialty hospitals and surgery centers are not a
5 new idea in Columbus. They're not a new idea in the State of
6 Ohio or most of the United States. Currently in Central
7 Ohio, OhioHealth, Mount Carmel and Ohio State all are in the
8 process of building specialty heart hospitals. Within the
9 Mount Carmel Health System, St. Anne's is currently
10 constructing a specialty women's hospital. It is widely
11 acknowledged and accepted that organizing care around a
12 particular disease or population, such as children, creates
13 tremendous efficiencies and precipitates better patient
14 outcomes.
15 Our new orthopedic specialty hospital affords the
16 same benefits to the community. It seems, however, that the
17 current dominant market leaders would prefer that the
18 creation of these new specialized centers only be permitted
19 if undertaken by them rather than others.
20 The natural barriers to entry for a potential
21 entrant into the marketplace, money and acceptance are
22 supplemented and strengthened in the Columbus area by the
23 existing hospitals. These competitors are using several
24 actions as barriers to entry. Threats of denial, staff
25 privileges to physicians who invest in NASH, adverse

1 publicity about NASH, and legislative lobbying to try to
2 obtain legislation that would bar physicians from referring
3 patients to in-patient hospitals in which they have an
4 ownership or investment interest.
5 Our specialty hospital will provide better patient
6 care at a more reasonable price and in a more patient-
7 friendly and caring environment. The argument for
8 specialization in health care is too compelling and affords
9 too many benefits to be thwarted either by policy or anti-
10 competitive conduct. Instead, we must encourage superior
11 models of health care delivery to promote innovation and
12 stimulate improved performance, higher patient satisfaction
13 and better outcomes.
14 NASH has also been maligned in Ohio and criticized
15 for being a for-profit facility. This is a little akin to
16 "the pot calling the kettle black." OhioHealth, Mount Carmel
17 and OSU all have owned for-profit physician practices,
18 diagnostic centers and surgery centers. OhioHealth and OSU
19 house for-profit specialty hospitals on segregated floors
20 within their own hospitals.
21 Nationally, there are over 750 for-profit
22 hospitals across the country, and they are an integral part
23 of our national health care delivery system. Many of these
24 hospitals are affiliated with religious institutions, others
25 with major universities. The Cleveland Clinic, the most

1 prestigious medical facility in Ohio, operates its Florida
2 hospital as a for-profit facility.
3 MS. MATHIAS: Mr. Alexander?
4 MR. ALEXANDER: Yes.
5 MS. MATHIAS: You need to wrap it up, please.
6 MR. ALEXANDER: Okay. I'll quickly say that our
7 struggles need not to have come at all. We made overtures to
8 the hospitals in Columbus to actually be our partner, but
9 were rebuffed. In addition to engaging in economic
10 credentialing, the hospitals in Columbus are essentially
11 colluding. An OhioHealth media spokesman basically said in a
12 September news article, "We are all on the same page. The
13 coalition is far enough along now. It's just an
14 understanding, we're all on the same page."
15 In closing, let me reiterate that Surgical
16 Alliance Corporation and the NASH physician partners have a
17 primary interest in creating in the New Albany Surgical
18 Hospital, a specialized environment that not only assures,
19 but nurtures, collaboration among the most skilled medical
20 and support staff, which, when combined with high quality
21 patient care that is focused on a distinct specialty, results
22 in better patient outcomes.
23 Thank you for your time and attention.
24 (Applause).
25 MS. MATHIAS: Thank you.

1 DR. MOREHEAD: I'm here to tell you a simple
2 story. And, Edward, after your presentation, to use a Paul
3 Harvey term, maybe the rest of the story. Our story begins
4 in the first few months of calendar year 2002. Members of
5 the OhioHealth Board of Directors learned of two different
6 orthopedic groups that planned to build competing orthopedic
7 hospitals that provided in-patient services; that is, beds,
8 whereas in-patients would be admitted.
9 The news invoked intense concern among members of
10 the Board of Directors. First of all, these were
11 orthopedists who had practiced for many years in our
12 facilities. Second, they were concerned about the impact on
13 the overall health care delivery system in Columbus. For
14 many years, the four major providers of care, hospital
15 providers of care, in Columbus had provided excellent,
16 effective, efficient services in Columbus and, in fact, all
17 of the uncompensated care without a tax base. They were
18 concerned whether or not their hospitals could continue their
19 missions, because it is correct, as you've already heard this
20 morning, that it is the profitable services they are taken
21 away that jeopardizes a hospital's capability of providing
22 unprofitable services.
23 And, finally, they were concerned about taking any
24 action at all against the medical staff. It is highly
25 unusual for the Board of Directors to have an adverse impact

1 on the interests of their medical staffs.
2 The Board set out on a journey, and the journey
3 was a journey of discovery. And the discovery was to analyze
4 in great detail these different concerns that they had and to
5 develop a response. I wish that I could introduce you to our
6 Board. You'd be impressed, like I'm impressed. Twenty-eight
7 outstanding leaders in our community; industrialists,
8 bankers, lawyers, physicians, dentists, psychologists,
9 business owners. These are people, some of whom represent
10 the largest employers in the Columbus and surrounding areas.
11 All are volunteers. All are deeply committed to the best
12 interest of the community. None are compensated, nor do they
13 receive any perks. These are people who are doing a
14 difficult job because their heart is in their work.
15 I want to review for you the journey of discovery
16 that led this group of committed, thoughtful, credible
17 citizens in Central and Southern Ohio to make a very
18 difficult and a very painful and a very bold decision to
19 terminate or withhold privileges from physicians who invest
20 in a for-profit, limited-service hospital which provides in-
21 patient services. Now, as I say this, I realize that we're
22 in the midst of a national debate, and that is good. But
23 this is the story of a single group of people who made the
24 decision that they could.
25 I'll go through some of the insight that the Board

1 had and struggled with as they discussed this over a six to
2 eight-month period. First of all, the Board members realized
3 very quickly that they had the fiduciary interests of the
4 charitable trust. Ohio law very clearly places the burden of
5 protecting the charitable interests of non-profit hospitals
6 upon the Board of Directors. They are responsible for
7 monitoring and maintaining and preserving fiscal stability.
8 They must protect the non-profit corporate interests. In
9 hospital lingo, that is protect the hospital mission. That's
10 their job, and they set about with great energy to be
11 faithful to that trust.
12 The first thing that they responded aggressively
13 to was the insight that investment in a competitive in-
14 patient facility created a very severe conflict of interest.
15 Let me describe conflict of interest as we see it. Conflict
16 of interest is when a physician has privileges, and that
17 means the ability to admit patients to different hospitals,
18 but that physician has a financial interest in one of those
19 two hospitals. The concern is self-evident: A physician
20 would make a decision to admit a patient -- that was
21 profitable -- to the hospital in which he or she had that
22 financial interest to enhance return.
23 I'd like to talk about this conflict of interest
24 in two different ways. First of all, I'd like to describe
25 the inherent conflict of interest. Good, competent,

1 dedicated physicians want to send their patients to
2 facilities where the level of care, sophistication of care,
3 is appropriate to the needs of the patient.
4 Let me give you an example. It's totally
5 different from replacing a knee in a 50-year-old weekend
6 athlete than a hip in a 75-year-old person who has severe
7 diabetes and who has had multiple episodes of heart failure
8 in the past. In that latter situation, one would like that
9 sicker patient to be hospitalized in a place where
10 endocrinologists, where infectious disease experts, where
11 cardiologists are available at the drop of the hat if
12 something should go wrong.
13 The inherent problem is that that latter patient
14 that I described for you, the sicker and older patient, is
15 also the least profitable and is more likely not to have
16 adequate insurance coverage. But there is also a financial
17 conflict of interest, again described earlier, the temptation
18 or the trend, tendency for a physician to refer a patient to
19 a hospital in which he or she has some ability or some
20 probability of receiving some financial advantage.
21 Now, this concept is not new. And concerns from
22 society over this conflict of interest in financial terms
23 goes back to the anti-kickback laws, goes back to Stark I and
24 II. Ohio itself has some state laws to the same effect. And
25 it's as though society has said to physicians, "We're willing

1 to pay you for direct patient care, but we really don't want
2 you to make money on your decisions that don't involve direct
3 patient care." That's been society's stance to this moment
4 and that was a major conclusion from the Board.
5 Let me point out right away that competition is
6 not the issue. Competition is good. Competition in terms of
7 quality of care and service is very healthy, and it will make
8 us all better. But competition ought to occur on a level
9 playing field. There should be some justice in the
10 competitive rules. The model used to develop for-profit
11 boutique hospitals in the past has always been to capture
12 physician investors, so that referrals will be guaranteed.
13 Physicians determine where a patient goes for
14 care, some 80, 90 percent of the time. And to give the
15 physician of referring patients to a facility in which he or
16 she has financial interest appears to the OhioHealth Board as
17 being definitely unfair competition.
18 The Board decided that it was not required, in
19 face of these insights, to sacrifice the interests of their
20 charitable institution in favor of the physician's self-
21 interest, and this was particularly notable because of the
22 strong affiliation and the rich heritage of the Methodist
23 Church, of which OhioHealth is a part.
24 I'll never forget one of our Board members sitting
25 in the Board meeting, and we had had a lively and a spirited

1 discussion, as many of them were. And he finally pounded his
2 fist on the table and he said, "You know, you just can't be a
3 partner and a competitor at the same time." And that's a
4 fairly self-evident statement from one who struggled with
5 this issue.
6 I'd like to close my comments and read to you a
7 quote. Last week my sister and I came to Washington on a
8 sightseeing tour. And we happened upon the FDR exhibit, and
9 I took a picture of one of the quotes from FDR, and I'd like
10 to read that to you. "The test of our progress is not
11 whether we add more to the abundance of those who have much.
12 It is whether we provide enough to those who have too
13 little."
14 I thank you.
15 (Applause).
16 MR. REX-WALLER: Well, thank you to the Department
17 of Justice and the Federal Trade Commission for organizing
18 this hearing, and I appreciate the opportunity to participate
19 on the panel. I'm John Rex-Waller, and I'm at this hearing
20 representing both the interest of my company, National
21 Surgical Hospitals, and the American Surgical Hospital
22 Association, of which NSH is a founding member.
23 The American Surgical Hospital Association is, in
24 fact, a 68-member trade association representing companies
25 that are involved in the development and operation of

1 freestanding specialty surgical hospitals. We're pleased
2 with the FTC and the Department of Justice's interest in
3 competition in our industry. We're yet a relatively small
4 part of the $1.3 trillion that is spent on health care in the
5 U.S., but I think we're on the leading edge of health care
6 innovation in this country.
7 Given the opportunity to participate on a level
8 playing field, free from unfair trade practices, specialty
9 surgical hospitals create choice and provide competition in
10 the health care marketplace, in addition to providing
11 superior patient care.
12 Defining specialty surgical hospitals is tough.
13 And a single definition is almost impossible. Attempts have
14 been made to define the specialty hospital as a single-
15 specialty orthopedic or cardiac; or by type of service:
16 surgical; ownership, by physicians; or whether it's
17 freestanding or within a hospital. All of these
18 categorizations fall short, as there is a matrix of all of
19 these, and multiple examples can be found in every single
20 cell of the matrix.
21 Just as an example, Cache Valley Specialty
22 Hospital is a small, multi-specialty surgical hospital with a
23 full emergency department, a full imaging center, four
24 operating rooms and 18 beds, in Logan, Utah. El Paso is a
25 60R, 31-bed facility in El Paso, Texas, with an emergency

1 room. And in San Antonio, the Spine Hospital of South Texas
2 is not a full-service multi-specialty facility. It focuses
3 on spine surgery only. That's the only thing that it does.
4 It just does spine surgery. It has an E/R, as it is mandated
5 by the state licensing requirements for an acute care
6 hospital. All of these facilities have acute care hospital
7 licenses and they all are subject to EMTALA. We take our
8 EMTALA responsibilities very, very seriously.
9 Whatever form they take, the case for the
10 specialty surgical hospital is compelling. These facilities
11 have arisen from a demand from physicians, patients and
12 payors, for a more efficient patient-friendly and cost-
13 effective location to provide medical care that has been
14 traditionally provided in the full-service hospital.
15 Although perceived as a new phenomenon, these hospitals are
16 simply another manifestation of trends that have been evident
17 for decades.
18 Witness the growth in ambulatory surgery centers
19 from which surgical hospitals have grown. No single factor
20 can be said to be the cause of the unbundling of surgical
21 care from the full-service hospital. Rather, it's the
22 confluence of the following factors that have caused the
23 emergence of the ambulatory surgery center 25 years ago and
24 that continue to drive the growth in surgical hospitals
25 today. We're simply an outgrowth of this industry.

1 In excess of 80 percent of all surgical cases are
2 done in an out-patient setting. This is up from less than 20
3 percent in 1980. On average, 85 percent of the cases done in
4 our surgical hospitals are done on an out-patient basis.
5 During the past few decades, surgery has been transformed as
6 surgeons and their patients have migrated to ambulatory
7 surgery centers and more recently their close cousins,
8 surgical hospitals.
9 This has been driven by technology, technological
10 advances, particularly in endoscopic surgery and in surgical
11 techniques and in advanced anesthetic agents. It's also
12 physician demand for efficient surgical facilities and
13 specialized staff dedicated to elective procedures. It's
14 also patient demand for a non-institutional, friendly,
15 convenient setting for their surgical care, and payor demand
16 for cost efficiencies as evidenced by the ambulatory surgery
17 center industry, as well.
18 Secondly, physician input and control. It has
19 been our experience that without exception specialty surgical
20 hospitals are developed in response from local surgeons.
21 It's a demand born out of frustration with local acute care
22 hospital management that is unresponsive and unable, or
23 perhaps unwilling, to meet surgeon and patient requirements
24 for all sorts of reasons.
25 Physicians feel a loss of control of their

1 practices and are demanding to regain control of their work
2 environment. The facility that allows surgeons to start on
3 time, do more cases in a given amount of time, and get back
4 to their office on time has a huge impact on their practice
5 efficiency. So, surgeons have decided to put their own money
6 and reputations at risk and have developed their own surgical
7 facilities which will be less bureaucratic, less political,
8 more accountable, and will provide better, physician-
9 oriented, patient-friendly, superior patient care.
10 The consumer choice movement, patients as
11 consumers, the single largest growth sector within the
12 managed care industry is the point-of-service plan. This
13 allows patients to choose their own provider. Patients are
14 voting with their feet, moving to plans that give them
15 freedom of choice. What patients want is more control, more
16 personal attention, and again, a less institutional
17 environment and better value, all of which are provided in a
18 specialty surgical hospital.
19 Last on this topic: Employee satisfaction.
20 Nurses are the principal employees of a hospital. The
21 working environment in a large hospital, and in any large
22 institution for that matter, distances employees from their
23 customers, the patients in this case, and administration.
24 Nurses are unhappy with their work environment, and they've
25 left the profession in droves, leading to the chronic nursing

1 shortage that we have.

2 Smaller work settings offer a better, more
3 customer-focused service orientation and a smaller, flatter
4 administrative structure. Just being small makes it a lot
5 more convenient for employees to work there. It makes a
6 specialty hospital a better work environment. And hopefully
7 the growth of these smaller, friendlier facilities will
8 encourage nurses to return to this very noble profession.

9 Let me turn to some of the threats that I think we
10 see on our horizon. I hope you sense the optimism that I
11 hold for the future of specialty surgical hospitals. And the
12 optimism is based on the fundamental soundness of this model
13 of delivering surgical care and on the superior quality care
14 results that we are seeing.

15 Surgical hospitals are the right thing at the
16 right time for quality patient care. Unfortunately, there
17 are a few dark clouds on the horizon that temper my optimism.
18 Specialty hospital owners and management are witnessing an
19 increase in the frequency and intensity of hostile anti-
20 competitive behavior aimed at our facilities and our
21 physician partners. I'm not speaking about the kind of
22 vigorous and healthy competition you'd expect as a new
23 business in town. I'm rather referring to conduct that can
24 best be described as predatory or exclusionary.

25 And here are some of these abuses that we are

1 seeing: Exclusionary contracting; economic credentialing,
2 where the owning a competing facility is cause for the
3 removal of a physician from staff; abuse of the appeal for a
4 CON process in those states where there are CONs; regulatory
5 legislative efforts to encumber specialty facilities with
6 unnecessary regulation and mandatory services. I'll comment
7 on that later if we have time. Direction of cases through
8 hospital ownership of captive health plans. The salaried
9 physician to captive health plan referring into an existing
10 hospital. That's certainly a clear conflict of interest.
11 Threats and actions against surgeons in allocating prime
12 operating room times. It happens all the time. Threats and
13 actions and interference in the referral patterns of primary
14 care physicians to specialists.
15 We're not so naive as to expect that when we
16 announce to a community the development of a new competing
17 hospital it will be welcomed with open arms by the existing
18 acute care hospital, but truthfully, we've been surprised and
19 disappointed by the antagonistic and sometimes irrational
20 contact we've encountered. For example, in Logan, Utah,
21 Logan Regional is an IHC, Inter-Mountain Health Care,
22 hospital located in Northern Utah. When faced with
23 competition from a new surgical hospital, Logan Regional did
24 not hesitate to use its size and contracting power. Logan
25 Regional and IHC, which control approximately 75 percent of

1 the health plan enrollees in the state, became very punitive
2 in contracting with payors that dared contract with the
3 surgical hospital.
4 IHC restricted access to its primary health care
5 network, which effectively limited payors to one hospital in
6 the market. Logan Regional -- and that was Logan Regional.
7 The surgical hospital is now denied access to enrollees under
8 contract with the IHC health plans and there are few
9 independent payors who are willing to forego the exclusive
10 IHC contract in order to contract with the surgical hospital.
11 IHC is also heavily involved in the employment of
12 primary care physicians in an effort to control the referral
13 base for its hospitals. They employ approximately 60 percent
14 of the primary care physicians in that local market. Non-IHC
15 primary care physicians have great difficulty contracting
16 with the IHC plans, unless they support that IHC system.
17 Coeur d'Alene, Idaho. When Kootenai Medical
18 Center learned that several physicians on its medical staff
19 intended to partner in development of a surgical hospital,
20 the reaction was open hostility. The Board, acting under
21 questionable state legal authority, passed resolutions
22 threatening physicians with expulsion from medical staff
23 because of their investment decisions, with no regard to
24 their professional performance. Physicians are being ordered
25 by hospital administration to disclose all financial

1 relationships with competing facilities, so that the hospital
2 may use this information in its medical credentialing
3 process.
4 Durham, North Carolina. Duke University Medical
5 Center controls over 98 percent of the surgical market in the
6 Durham, North Carolina area. The sole competitor is a small,
7 privately owned facility that exists in a 77-year-old leased
8 facility, incidentally that's been physician-owned for the
9 last 77 years. The owners of the specialty surgical
10 hospital, seeking to deliver existing surgical services in a
11 replacement facility that will meet current health and
12 building codes, applied to the state CON authority for
13 permission to relocate existing operations.
14 The specialty hospital sought permission to
15 provide the same services at approximately the same capacity
16 level. Response from Duke, has been open aggression, Duke
17 marshaled its resources to contest the facility upgrade,
18 knowing that if it could lock the specialty hospital into a
19 77-year-old facility, that it's going to suffocate the
20 remaining source of competition. They've also, as we're
21 seeing in many other places, restricted staff privileges.
22 The response has not just been on the local level.
23 It has also come from an earnest and public effort by such
24 large and well-funded organizations as the California Health
25 Care Association and the AHA. The AHA -- at least ASHA and

1 National Surgical Hospitals certainly hope that the
2 Department of Justice and the FTC
3 take note of these concerted efforts by large hospitals and
4 associations to impede, if not eliminate, the development of
5 specialty surgical hospitals.
6 Just as the development of surgery centers was
7 first opposed, but I note later embraced whole-heartedly by
8 hospitals, they are now opposed to the next innovation -- the
9 delivery of surgical care. That is, unless, of course, it's
10 they and not a new competitor who is delivering the new care.
11 The old-line establishment of health care cannot
12 be so parochial as to believe that blocking progressive forms
13 of health care delivery is in the best interest of our
14 nation, our communities or our patients. I think that a
15 quote from Roscoe Starek, who is a former FTC Commissioner,
16 and this was echoed by Chairman Muris in November of last
17 year, is appropriate. He said, "The Commission does not
18 favor one type of health care delivery system over another.
19 Rather, we work to keep markets open to new and existing" --
20 my emphasis -- "competition so that consumers and providers
21 can make their economic decision. The Commission seeks to
22 ensure the delivery systems may develop and grow if they meet
23 the preferences and needs of consumers and that anti-
24 competitive behavior does not impede the development of
25 health care alternatives." I think this must be the position

1 of federal and state policy.

2 We encourage the FTC and the Department of Justice
3 to actively promote innovation in the delivery of surgical
4 care by doing everything possible to prevent the anti-
5 competitive behavior that threatens the viability of our new
6 and recent industry. Thank you very much.

7 MS. MATHIAS: Thank you.

8 (Applause.)

9 MR. MUHOLLAND: Good morning, everybody. My name
10 is Dan Muholland. I'm from the law firm of Horty, Springer
11 and Mattern in Pittsburgh, Pennsylvania. We're a single-
12 specialty law firm of 14 attorneys who only represent
13 community hospitals around the country. We have over 300
14 active hospital clients in all 50 states. And let me just
15 preface these remarks by saying that in making the
16 presentation today I'm only representing the views of myself
17 and the firm and not of any client. We're not here on behalf
18 of any client.

19 I'd like to thank the Department of Justice and
20 the Federal Trade Commission for this opportunity. The last
21 time I had any official communication with the FTC was when
22 they served a subpoena on me, trying to depose me regarding
23 legal advice I gave in the Freeman Hospital merger case.
24 But, fortunately, that had a happy ending, and it's nice to
25 be here on less than contentious terms.

1 As I said, all we do is represent hospitals. And
2 not a day goes by that we don't get a call involving this
3 particular issue: The effect of carve-out competition,
4 single-specialty hospitals, out-patient surgery centers or
5 independent diagnostic facilities on community hospitals and
6 their ability to perform the services that they provide to
7 the public.
8 And I just wanted to make a few observations today
9 in response to the questions that the FTC and the DOJ raised
10 regarding this issue. Now, many of these have already been
11 discussed by the other speakers, so I won't dwell on them,
12 but there are a few things that I think need to be covered,
13 in addition to the observations already made.
14 As to the factors that drive the unbundling of
15 hospital in-patient services, it isn't all about money, but
16 that's a big part of it. Obviously, doctors would like to
17 supplement their professional income with the facility fees
18 or technical component income that comes with having an
19 ownership interest in a facility. But that's really a small
20 part of it. Another big revenue driver is the fact that
21 because of some of the efficiencies that can be done in a
22 facility only devoted to one specialty, they're able to drive
23 more volume through the facility and thus increase revenue
24 that way.
25 Most of these organizations do not have the same

1 level of charitable obligations or commitment as their non-
2 profit counterparts because they're organized as for-profit
3 facilities. And in many cases, but not all, as some of the
4 speakers observed, they have minimal amount of existent
5 emergency obligations. Even when they do have an emergency
6 room because they're focused on a single specialty the scope
7 and type of emergency services they have to offer, especially
8 with respect to the emergency room call coverage that has to
9 be provided in different specialties, is limited.
10 Finally, one thing that's often overlooked is that
11 the single-specialty hospital, when it involves physician
12 investors, gives the physicians an opportunity for diagnostic
13 revenue, from MRI, CT scans, nuclear cardiology. This tends
14 to be fairly high-paying, along with some of the procedural
15 things done in the hospital that wouldn't otherwise be
16 available to them -- either because of the type of things
17 that they can have in their office or some of the existing
18 legislation and regulation that applies to relationships
19 between physicians and entities to whom they refer services.
20 Some of the fraud and abuse laws have quite the
21 opposite of their apparent intended effects in terms of
22 driving more hospitals and more physicians towards ownership
23 interests in single-specialty hospitals. Of course the Stark
24 "whole hospital" exception specifically permits doctors to
25 have an ownership interest in the hospital. But the in-

1 office ancillary service exception is fairly limited and
2 would not allow competing physician groups to pool their
3 resources, except in rural areas, to get diagnostic revenue
4 outside of the diagnostics that they can offer in their
5 offer.
6 Finally, the safe harbor by the Office of
7 Inspector General on ambulatory surgery centers limits
8 participation to physicians who do a predominance of their
9 work in an outpatient setting. So, if you had an orthopod,
10 for instance, who did a lot of hips or a lot of complicated
11 in-patient procedures, that orthopod might be outside of the
12 safe harbor for a surgi-center, but could come back into a
13 safe harbor with respect to ownership interest in a whole
14 hospital.
15 Now, what have been the effects of this
16 unbundling? Well, a lot of the speakers have mentioned that
17 physician ownership interests influence referrals. That's
18 almost intuitive. And there have been some studies that
19 suggest that utilization increases. The real problem,
20 however, is how this kind of competition can adversely affect
21 a full-service community hospital. Hosptals may be the
22 victims of patient dumping or cherry-picking in terms of more
23 highly paid patients having services done in a physician-
24 owned hospital as opposed to the full-service hospital;
25 whereas those physicians would still treat indigent patients

1 or Medicaid patients in the hospital.

2 We once looked at -- very recently, one of our
3 clients in Tennessee who was looking at some competition from
4 some surgery centers, once the surgery center opened, one of
5 the orthopods on staff had previously done only about 20
6 percent of the work in the hospital was Medicaid work --
7 TennCare as it's called in Tennessee. After the surgi-center
8 opened and the doctor moved most of his practice there the
9 doctor's TennCare load at the hospital jumped to about 80
10 percent. This suggested that he was using the hospital
11 almost exclusively for his TennCare patients and diverting
12 his paying patients to the surgery center.

13 Another thing that's often overlooked is that
14 staffing shortages (which are already pretty bad in various
15 nursing specialties, anesthesia providers and pharmacists, as
16 well as some technical professions) become much worse when a
17 new hospital opens, a single-specialty hospital, opens in a
18 community. Already short staff are diverted over to that
19 hospital, bidding up the costs of nursing services and other
20 technical support services for all the hospitals in the
21 market.

22 Peer review sometimes can be ignored or even
23 outright abused. There was an example of that recently in
24 the plea bargain case in Michigan, where a hospital and two
25 of its medical staff leaders pled guilty to various fraud

1 charges because, according to the Department of Justice, they
2 had not properly peer-reviewed a physician who was performing
3 allegedly unnecessary pain management procedures. When the
4 Department of Justice conducted its investigation, it
5 determined that the two medical staff leaders involved had
6 deliberately, according to the indictment and the plea
7 bargain that the hospital entered into, tried to cover up
8 this problem because they had a common investment interest in
9 an out-patient surgery center with the anesthesiologist
10 performing pain management procedures. Finally, Board and
11 medical staff relationships deteriorate and you have outright
12 civil war in many institutions.
13 Now, has quality of care been enhanced as focused
14 factories emerged? I think the jury's still out on that.
15 There are a number of articles which we have in our
16 presentation, and you are welcome to have copies of it later,
17 which suggest that sometimes in for-profit facilities quality
18 isn't on the same par as non-profits. There are other
19 studies that reach the opposite conclusion; the Lewin Group
20 recently did a study of some procedures in heart hospitals.
21 But the bottom line is that at some point, even though
22 increased volume in many cases can enhance quality, it
23 reaches a point of diminishing returns. And if there are too
24 many incentives to drive procedures through quickly and to
25 drive high volumes of procedures through a facility, quality

1 can begin to suffer.
2 Have costs and access been increased or decreased?
3 Well, we think that cost increases are quite likely as a
4 result of this competition, as the result of increased
5 utilization, competition for the support staff that I
6 mentioned, as well as duplication of facilities in
7 communities that probably don't have the demand to support
8 two facilities unless, as the Professor suggested, it's
9 supply-induced demand.
10 Access can also decrease as a result of the
11 limited charitable commitment of the physician-owned single-
12 specialty hospital, and reduced incentives for the physician
13 investors to provide E.R. call coverage and related services
14 at their full-service community hospital competitors.
15 Now, has competition been affected for services
16 provided by the general in-patient hospital and single-
17 specialty hospital, as well as for services provided only by
18 the general in-patient hospital? I think this happens in
19 both instances. Certainly competition is affected when you
20 introduce a new competitor in the market for the single-
21 specialty hospital. But in some markets, where general
22 hospitals have invested in a single-specialty opportunity
23 with outside investors in their positions, it's an
24 interesting mix in that sometimes their ability to provide
25 the full range of services outside of that single specialty

1 becomes diminished and they become a weaker competitor of
2 their fully integrated, full-service counterpart.
3 Is this development any different than the
4 emergence of specialized hospitals for children, rehab or
5 psych? Well, I'd suggest that if it wasn't different we'd be
6 seeing a lot of for-profit plays in obstetrics and pediatric
7 hospitals. We simply aren't seeing that. We're seeing it
8 when there is a possibility of favorable reimbursement, which
9 makes sense from the standpoint of the investors.But
10 traditional specialized hospitals usually serve populations
11 with limited reimbursement and high numbers of indigent
12 patients.
13 Physician ownership, however, will skew
14 competition. Basically, the physician owners of a hospital,
15 single-specialty or otherwise, will have a de facto exclusive
16 arrangement with that hospital. And because of that de facto
17 exclusive arrangement, their decisions about where and how
18 care is provided will be influenced by that investment
19 interest.
20 But what actions have hospitals taken in response
21 to the emergent single-specialty competitors? Well, there's
22 a number of things. Some people mentioned preferred and
23 exclusive managed care contracts. We helped litigate the
24 Surgery Care Center of Hammond case in Louisiana recently
25 where the Fifth Circuit ruled in favor of the hospital. At

1 the nub of that controversy were some preferred relationships
2 that North Oaks Medical Center had entered into with managed
3 care providers in the New Orleans area. The surgery center
4 complained that this constituted attempted monopolization,
5 but the court found in favor of the hospital. First by
6 saying the hospital lacked market power; and second by saying
7 that even if it had market power, this would be a reasonable
8 way to compete -- basically trading lower volume or lower
9 prices in return for higher volume.
10 Refusal to cooperate with single-specialty
11 hospitals, we think it's perfectly legitimate. And this
12 issue came up in the North Oaks case, as well, for a full-
13 service hospital to decline to enter into a transfer
14 agreement with a single-specialty hospital or surgery center,
15 unless the surgery hospital or specialty hospital agrees to
16 indemnify the full-service hospital for uncovered costs as a
17 result of the transfer.
18 We also have seen a number of things that
19 hospitals have done to compete with single-specialty
20 hospitals by way of denying certain types of relationships to
21 physician investors. This was discussed by a number of the
22 previous speakers. Certainly, we would think that a
23 physician who has an investment interest in a competitor
24 would be barred from board membership on a full-service
25 hospital by virtue of the fact that this would violate the

1 fiduciary duty of loyalty, as well as possibly causing some
2 problems under Section 8 of the Clayton Act.
3 Hospitals have also determined to deny medical
4 staff leadership positions or participatory rights, for
5 example, votes or active staff membership, to physicians with
6 investment interests in competitors. And some hospitals have
7 determined that this could disqualify physicians from medical
8 staff appointment and clinical privileges, as well as
9 financial relationships like recruitment contracts or medical
10 directorships with the full-service hospital.
11 In all of these cases, we think an antitrust
12 analysis would lead one to the conclusion that these are
13 perfectly reasonable and pro-competitive responses to this
14 type of competition. Remember, that in Sherman I most of
15 these cases will be analyzed under the rule of reason. Under
16 Sherman II, attempted monopolization cases, there are
17 concerns about predatory conduct. To the extent that these
18 are reasonable responses, we think that those responses will
19 be deemed appropriate.
20 There are a lot of cases, which I won't go
21 through, that have dealt with this and suggested that this
22 kind of so-called economic competition or credentialing,
23 which we feel is a pejorative term, would be all right. In
24 the end, however, we reached a conclusion in dealing with our
25 clients that this trend can be extremely harmful to a

1 community's ability to provide for its health care resources.
2 And when we work with hospitals, we usually tell
3 them to suggest to their physicians that because of all of
4 the other hostile factors in the health care environment
5 today that it's best that they stick together, and that they
6 quote Ben Franklin to them, by saying that, "We all have to
7 hang together, or else we'll hang separately." And if that
8 doesn't work, we revert to the immortal words of Bart
9 Simpson, who said, "Listen to your heart, not the voices in
10 your head."
11 (Applause).
12 MR. KELLY: Good morning. My name is Dennis
13 Kelly. I serve as Executive Vice President of Development
14 and Government Relations for MedCath Corporation. MedCath is
15 a national provider of cardiovascular services, publicly
16 traded and headquartered in Charlotte, North Carolina.
17 Currently we have approximately 5,000 employees throughout
18 the United States.
19 We appreciate the opportunity to speak on behalf
20 of our organization, our physician partners, other
21 professional staff, and the patients who have utilized our
22 hospitals and our services. I want to especially thank the
23 Federal Trade Commission and Department of Justice for
24 framing the following questions for our response. And those
25 questions have been covered previously: the factors driving

1 the development of our hospitals; what has been the effect of
2 our hospitals in the marketplace; have our hospitals enhanced
3 quality of care; have cost and access decreased as a result
4 of our hospitals; how has competition been affected; and what
5 actions have competitors taken in response? I'll take a few
6 minutes trying to address some of that.
7 It's interesting that -- you know, I'm glad to see
8 that everybody agrees about this issue. We have a unique
9 sort of circumstance. Because of our operational experience
10 we hope to bring the discussion from the theoretical to the
11 actual because we've got results. We now run and operate 10
12 heart hospitals in partnership with physicians.
13 MedCath has a clear vision to redefine the way
14 cardiovascular care is delivered throughout the United
15 States. Our mission is to improve clinical outcomes for
16 cardiac patients through a physician-driven, patient-focused
17 approach. Our values are people, partnership, quality and
18 integrity.
19 Let me talk a little bit about what is a MedCath
20 heart hospital because it's not been described yet. This is
21 one of the challenges that I think we have as those that
22 passionately care about health care in the United States.
23 It's hard to characterize any one of these organizations or
24 facilities or structures because every market in the United
25 States is different and, therefore, market forces in each

1 market are somewhat unique to other places.
2 When we talk about a heart hospital -- that is a
3 freestanding, general, acute-care hospital designed to focus
4 primarily on cardiovascular care. We treat all patients
5 regardless of their ability to pay. And, in fact, studies
6 have shown that we either are comparable to the Medicaid and
7 indigent patient provision or we're in the top half in those
8 respective markets. The typical hospital has 32 to 112 beds;
9 all of these are intensive-care or coronary-care equipped.
10 Typically it has two to six cath labs and two to four
11 operating rooms. And we partner with physicians, both
12 economically and operationally.
13 The medical staff of our facilities also is a
14 little bit unique and candidly has not been described. We
15 have basically -- the typical staff is 250 to 300 physicians.
16 Of that 250 to 300 physicians, only 15 to 70, 15 on the low
17 end and 70 on the high end, the average probably 35, are
18 investors, but of that 250 to 300, that includes all of the
19 specialties you need to take care of everything that comes to
20 the hospital. And all of them are on call, and when you hear
21 some information related to our emergency visits, you'll get
22 an understanding of that.
23 We're committed to improving the productivity and
24 work environment of physicians, nurses and other medical
25 personnel providing care. And if I could tell you the one

1 single reason why doctors want to work with us, and not
2 speaking for anyone else, it's because of the care, the
3 control we have over the care provided for their patients in
4 the in-patient setting; the empowerment within the hospital
5 to help govern and set up the operating standards; and, third
6 and equally as important, the productivity enhancement it
7 provides to them because all of them are getting busier and
8 they need to find ways to be more productive.
9 I'd like to comment on the emergency services we
10 currently provide through our operating hospitals, and I
11 think this will be very telling. In fiscal year 2000, in our
12 eight heart hospitals, we treated a total of approximately
13 40,000 patients in our emergency departments. Of those
14 40,000 patients, roughly 24,000 were non-cardiac patients.
15 That makes up 59 percent. Of those 24,000 patients that were
16 the non-cardiac patients that presented in a MedCath heart
17 hospital in the emergency department, we only transferred out
18 of that hospital 681, less than 3 percent, to another short-
19 term hospital. This then tells you that we're treating the
20 majority of those patients and sending them directly home.
21 When you review the high percentage of our
22 emergency visits that are non-cardiac and the relatively low
23 percentage of these that we transferred to another short-term
24 hospital, the data refutes any argument that we are adding to
25 an overburdened network of emergency departments. The data

1 suggests the reverse is true. We are adding capacity to the
2 emergency system and are able to treat a significant portion
3 of the non-cardiac patients that come to our facility.
4 Also, on the other side of that, though, is the
5 transfers from other hospitals to our hospitals. I think
6 this gives you some idea of what is the role of our type of
7 hospitals in the communities that we serve. Transfers to
8 MedCath heart hospitals from other short-term hospitals, in
9 the last 12 months, through the end of February, we received
10 over 7,000 patients, in-patient admissions, from other short-
11 term hospitals. That represents 22 percent of our entire in-
12 patient admission base for that 12-month period.
13 The high percentage of our admissions that were
14 transferred from other short-term hospitals confirms that our
15 hospitals are providing a tremendous service to the regional
16 health care network by adding critical cardiac capacity to
17 the system. We believe the majority of these transfers come
18 from rural hospitals that are part of the 76 percent of all
19 hospitals in the United States that do not have open-heart
20 surgery. And when we talk about having a critical mass, as
21 several of the speakers have talked about, you know, if you
22 look at cardiac, and I'm not speaking for the other
23 specialties, cardiac is very unique. Seventy-six percent of
24 the hospitals in the United States do not have an open-heart
25 program. So, it's hard to say that you have to have that

1 program to survive.

2 One of the things that we've done is we look at,
3 obviously, to secure a lot of contracts, managed care and
4 third-party contracts in the United States, you have to have
5 your facilities reviewed and certified by the Joint
6 Commission on Accreditation. This gives you the latest
7 survey results for all of our hospitals.

8 Competitive impact: What has been the impact of
9 our hospitals in the markets that we enter? We increase
10 access to cardiac-monitored beds; we improve access to
11 emergency services; we improve clinical outcomes; we reduce
12 the costs resulting from shorter hospital stays; a higher
13 percentage of our patients are discharged directly to their
14 home; and an efficient use of critical nursing labor pool.
15 If you, you know -- and this is a big issue. We have a labor
16 shortage, a nursing shortage throughout the United States. I
17 can tell you that if you give us the same 100 nurses that you
18 give another health system that's doing cardiac care, we'll
19 treat more patients with those 100 nurses.

20 Higher patient satisfaction -- it's a new
21 competitive benchmark in the marketplace. We measure lots of
22 things. One of the things we measure is patient
23 satisfaction. This gives you an idea. We try to survey
24 every patient upon discharge, and this just gives you some
25 idea of how patients feel about being treated in one of our

1 facilities. The thing we look at, of course, is the very
2 last one, would you return, and that scored 98 percent as a
3 cumulative score for the last three years.
4 Let's talk a little bit about this issue of
5 outcomes. The good news is that the Lewin Study -- Lewin is
6 a nationally recognized health and human service research
7 firm -- does a lot of work looking at government programs, to
8 make sure that the value being provided for the government
9 dollar is a good value. We've looked at them now for the
10 better part of the last four years. They've done a lot of
11 research for us, and we've shared a lot of this research. I
12 think we're the only national health care company that
13 actually has released clinical outcomes and published those
14 results.
15 This is on a risk-adjusted basis, using a common
16 APR-DRG risk adjustment, similar to what the CMS has used for
17 years. If you look at it, in fiscal year 2000, we had eight
18 hospitals up and running. There were another 946 hospitals
19 in the United States that had open-heart surgery programs
20 that were not major teaching facilities. In addition, there
21 are 193 major teaching facilities. If you look at the bars
22 on the far right, the case mix index, you will see the red
23 bar, MedCath has a significantly higher case mix index than
24 both the peer community hospitals, as well as the major
25 teaching hospitals. And this is not a sample. This is all

1 Medicare discharges in the United States for fiscal year
2 2000. The length of stay for that population of patients was
3 on a risk-adjusted basis for -- everyone's been -- you know,
4 it's a comparable measurement, 4.12 for MedCath, 4.99 for
5 peer community, and as you can see, 5.31 for the major
6 teaching hospitals.
7 And the thing we look at most is in-hospital
8 mortality. Okay, we're treating a sicker population, or a
9 more complex patient population. They're in the hospital for
10 a shorter amount of time. What is the mortality at
11 discharge? And as you can see, we have a significant
12 difference in the mortality at discharge, which is why we
13 have such patient satisfaction and word of mouth referrals
14 from our patients.
15 In addition, one of the studies -- what the study
16 pointed out, what happens to our patients when we discharge.
17 Ninety percent of our patients are discharged directly to
18 their home versus 72 percent for the peer community hospitals
19 and 70 percent for the major teaching facilities. That
20 resulted in saving the Medicare program over $1,000 per
21 discharge for the discharges that we treated that year. We
22 treated 13,000 Medicare discharges that year. If you
23 extrapolate that out and just said, okay, the standard of
24 care we want for cardiovascular care is to have these kinds
25 of mortality measurements and this kind of length of stay and

1 discharge designation, and you apply that times the 1.5
2 million Medicare discharges during this same period, you
3 would have a savings to the Medicare system of $1.5 billion.
4 We recently received the data for 2001. The
5 results were very, very similar to what we had in 2000. In
6 fact, the deltas are larger now. Everyone's improved, which
7 we're grateful for, both the peer community hospitals, the
8 major teaching hospitals, and our facilities.
9 What actions have existing competitors taken? The
10 approach has been interesting. You've got -- as I just flip
11 through it -- you've basically heard all of them: economic
12 credentialing; trying to deny privileges at a hospital;
13 basically denying, as Cara talked about earlier, in one
14 market, the managed care plan is owned 50 percent by the
15 health system that has a dominant, monopolistic position in
16 that market. As soon as the hospital was opened, they took
17 the physicians off of that insurance plan, even for those
18 patients treated in their office and in the other hospitals
19 where the physicians have still, to this day, maintained
20 privileges. That's been one of the common things.
21 It's interesting, the emergency department is one
22 of the areas that concerns us the most, because on the one
23 hand, we're told, we want you physicians to continue to
24 support call panels at your community hospitals. On the
25 other hand, though, we're now going to take you off the

1 emergency department call rotation because we're trying to
2 punish you.
3 Additionally, they tried to remove the physician
4 from provider panels for hospital-sponsored or affiliated
5 insurance plans, managed care plans and others, as has been
6 talked about. Removing investor or potential investor
7 physicians from extra assignments under the control of the
8 hospital under which the physicians have the opportunity to
9 earn professional fees, for example, graphics panels that are
10 interpreting x-rays, EKGs, and ultrasounds that help
11 determine a patient's need of care. Removing a doctor from
12 the post as chief of cardiology at the competing hospital,
13 reserving these opportunities only for physicians that do not
14 support competition.
15 And then, in addition, probably the most
16 aggressive tactic that's been used is to go to a group of
17 physicians already in that market and basically tell them if
18 you'll leave the practice you're currently in, we'll go ahead
19 and guarantee your salary for the next two years, and we'd
20 like you to form your own group to come over. So, they're
21 basically just trying to fracture the existing practices.
22 What's interesting about all this to us is the,
23 you know, how do people view --
24 MS. MATHIAS: Mr. Kelly, I'm going to have to ask
25 you --

1 MR. KELLY: Yes, wrapping up. I just have -- so,
2 can I finish up now or --
3 MS. MATHIAS: Yes.
4 MR. KELLY: Okay.
5 MS. MATHIAS: Go ahead and finish.
6 MR. KELLY: The last thing I would like to do is
7 just share with you a letter that we received from the
8 Secretary of Health and Human Services, Tommy Thompson, last
9 July, upon the announcement of a project up in Milwaukee,
10 Wisconsin. "As your governor for 14 years, nothing was more
11 important to me than the health and well-being of my fellow
12 Wisconsinites. Now, as Secretary of Health of Human
13 Services, I'm focused on the health of all Americans, but I
14 don't mind saying that it's still Wisconsin that holds a
15 special place in my heart. That's why it's such joy to know
16 that Milwaukee and MedCath are joining to improve the quality
17 of cardiovascular care in Wisconsin. This is the sort of
18 public/private partnership combining the resources of
19 government with the innovation of the business world that
20 makes America great. In teaming together to find new ways to
21 serve your fellow Americans, you truly have shown yourselves
22 to be foot soldiers in what our President called the armies
23 of compassion. It is something to be proud of. As I said,
24 this is a great day for Milwaukee and Wisconsin. On this
25 site, you'll do more than just treat heart disease, you'll

1 give a father another day with his daughter; you'll give a
2 son a chance to have his own children; you'll give a mother
3 time to see her grandchildren. You'll save lives, my
4 friends, and there is no higher calling. For all this and on
5 behalf of the President of the United States, let me say
6 thank you; and on my behalf, congratulations on helping
7 cement Milwaukee's status as a first-class American city."
8 And I just, in wrapping up, would just like to
9 thank the Department and the Commission for looking at this
10 issue. Thank you.
11 (Applause).
12 MS. MATHIAS: Thank you. As promised, we'll take
13 about a 10-minute break and then reconvene.
14 **(Whereupon, a brief recess was taken.)**
15 MS. MATHIAS: There are a couple of things that I
16 wanted to remember before we begin again, because I'll forget
17 at the end of the day. First off, I think this is going to
18 solicit comments from numerous people. If you wish to submit
19 written comments, you are more than welcome to. If you look
20 at our website, there's a method and an address to send them
21 in to. If it's specific to this session, you have 45 days to
22 get those written comments in.
23 We will also post all the PowerPoint presentations
24 and written speeches that were given on our website in about
25 a week. Actually, I hope it's sooner than that, but we're

1 going to at least shoot for the week. And then later within
2 about 30 days, we'll have the transcripts from these sessions
3 also posted on the website. The extra materials are actually
4 on the FTC website, and not the DOJ website, because of
5 certain rules that the various government groups have, so I'm
6 sure Justice would love to have them, but it's just not an
7 opportunity that's available. So, I wanted to be sure to
8 mention those opportunities.
9 And, Bill, do you want to start with the first
10 question?
11 MR. BERLIN: Sure. This question really is for
12 anyone on the panel, but perhaps it's addressed to the people
13 that are more pro, is one group, and more con is the other
14 and then perhaps at the end Professor Frech and Ms. Lesser
15 could give an overview. And basically, it's pretty
16 fundamental, and that is: What is the impact on cost to
17 consumers and perhaps this could even be extended to quality
18 and access to care, of single-specialty hospitals?
19 On the one hand, I think that we've heard -- I
20 mean, I think the theme that I'm picking up is that as to the
21 particular specialty that a given single-specialty hospital
22 may be engaged in, that perhaps the cost could that lower
23 quality of care might be better, and patient access might be
24 better.
25 But, on the other hand, that perhaps it's

1 diminishing each of those factors, you know, market-wide when
2 you talk about the loss of income, loss of cross-subsidies to
3 hospitals.
4 So, I guess, to the people here that are on the
5 pro-single-specialty hospital side, what is your response to
6 that? Do you think that there is an overall loss to the
7 market as a whole? And for the other folks, sort of the flip
8 side of that, would you concede that perhaps costs are lower
9 to consumers for that particular specialty, but that is, you
10 know, outweighed by the overall detrimental effect?
11 MS. MATHIAS: And just a quick point, I think you
12 were done with your question?
13 MR. BERLIN: I was.
14 MS. MATHIAS: So that we -- I assume we have a
15 panel that wants to add a lot to all of these questions. To
16 help us organize and moderate, if you would like to answer
17 one of the questions, if you could just -- I know it sounds
18 silly -- but turn your tent sideways. That way we make sure
19 that you are recognized and we can address everyone that way.
20 Thanks.
21 MR. BERLIN: I mean, we'll start at this end if
22 you -- one of you want to jump in there, I'll pick on people,
23 since I wasn’t overly specific.
24 MR. KELLY: Would you like me to respond?
25 MR. BERLIN: Mr. Kelly, yes.

1 MR. KELLY: The issue, as I understand it, is that
2 you look at the cost, capital cost that you've added to the
3 marketplace when you expand a facility or a physical plant.
4 In health care, the largest component of cost on an operating
5 basis is labor. By having a -- cross-training your staff,
6 having everybody focus on one particular kind of disease, in
7 our case cardiovascular disease -- with that, of course,
8 comes everything else.
9 Typically if you have heart disease, a high
10 percentage of the population has diabetes, as well, and so we
11 end up dealing with a lot of renal disease, pulmonary
12 disease, neurological symptoms, all that come with the heart
13 patient, so we're able to do that.
14 But even with that, if you train people primarily
15 on the population we're trying to treat, then we believe that
16 we, you know, instead of spending 40 to 60 percent of your
17 total operating expense on labor, which is typical in the
18 United States in a fully integrated health system, we do that
19 at around 30 percent on a fully allocated basis. So, we know
20 that on that number, one driver of your cost, it's lower.
21 On the other hand, the device cost and supply
22 cost, because of the nature of cardiovascular disease, is
23 high, but it's high for every platform of care, not just for
24 the way we do it. We think we can get some advantages
25 because of consolidation in purchasing. Having the

1 physicians working directly with us is one of our advantages.
2 On the physical plant side, yes, we're adding, you
3 know, bricks and mortar and a physical plant, and so I think
4 it will take some time to figure out, you know, what's the
5 impact of that, adding that additional cost to the
6 marketplace. In some cases, there's pure consolidation, so
7 you introduce it, as Professor French said, you end up
8 basically closing or consolidating a couple of existing
9 programs for all the right reasons into that heart hospital.
10 And, therefore, in that case, it definitely is beneficial.
11 MR. BERLIN: Mr. Muholland?
12 MR. MUHOLLAND: I think that the cost on consumers
13 would widely vary, depending not only on market conditions
14 but on what kind of consumer you're talking about. The cost
15 to most consumers who either have governmental or private
16 health insurance is the out-of-pocket cost, the co-payor
17 deductible. And what we see a lot of markets, in terms of
18 some favorable effects on consumer cost, is the result of
19 what some of the single-specialty hospitals are complaining
20 about. Their full-service counterparts will negotiate an
21 exclusive or preferred relationship with an HMO, that the
22 exclusivity or preferred status comes in return for lower
23 prices. Those lower prices will eventually go down to the
24 consumer, as well.
25 On the other hand, we've seen some markets where,

1 if the physicians who participate as investors in the for-
2 profit single-specialty hospital do not have participation of
3 Medicare and Medicaid, they'll actually be doing Medicare and
4 Medicaid patients more than what they would be responsible
5 for out-of-pocket if they were participating providers.
6 And eventually, if there's excess capacity in the
7 market, in the aggregate, those costs ultimately will be
8 passed on to the consumer or the governmental entities who
9 pay for this over time. But when price competition breaks
10 out, as a result of the single-specialty hospital challenging
11 a full-service hospital, a full-service hospital trying to
12 negotiate a preferred relationship with managed care to
13 counteract that built-in exclusivity that comes with
14 ownership, consumers can benefit for a short period of time.
15 MR. BERLIN: Okay, Mr. Rex-Waller?
16 MR. REX-WALLER: I think there may, in fact, be a
17 short-term dislocation, and it could be short-term additional
18 cost, but I think over time, as I think Ms. Lesser pointed
19 out, we're seeing a number of markets where we're, in fact,
20 getting to the point of being under-bedded again, which we
21 haven't had for quite a while.
22 And, so, now we have an opportunity where those
23 additional costs are going to be absorbed by aging of the
24 population, particularly in the specialty that we look at,
25 which is in orthopedics. And, so, you're going to have --

1 that additional capacity is going to be taken up with the
2 natural growth in surgical specialty. So, short-term,
3 dislocation, yeah, possibly, but long-term, I think you're
4 right in capacity where it's appropriate.
5 MS. MATHIAS: George?
6 MR. LYNN: Thank you. I think the presence of
7 specialty hospitals adds costs to the system. In most
8 communities the resources that we talked about are present.
9 They may be approaching capacity, but the cost of adding an
10 O/R in a community hospital versus building a freestanding
11 hospital, I think, are obvious. One is significantly higher
12 than the other.
13 Typically, I think not-for-profit community
14 hospitals have a lower cost of capital by having access to
15 capital in many states through tax-exempt authorities. And I
16 think this whole notion of cost, as we think about it, if you
17 compared the cost of a community hospital and a specialty
18 hospital, if you removed the responsibility to provide care
19 for uninsured and under-insured, which is part of the
20 missions of those community hospitals, their costs would come
21 down substantially. So, that's a huge factor in terms of
22 cost.
23 In terms of quality, I just don't think there are
24 a sufficient number of specialty hospitals and studies done
25 to really enter into a discussion about quality. There's no

1 data that has really emerged from this. And we tend to kind
2 of talk in terms of specialty hospitals being generic, but
3 there are clearly differences between pediatric hospitals and
4 orthopedic hospitals and heart hospitals and cancer
5 hospitals. So, I'd avoid that blanket kind of view that says
6 that this model is superior in terms of quality. We know
7 enough about quality to know that it varies from community to
8 community. There are a lot of driving forces that are
9 impacting quality.
10 And in terms of access, I think if --
11 fundamentally in this discussion about a specialty hospital,
12 we're not talking about consumers making informed decisions.
13 We're talking about physicians driving volume. Someone once
14 said as the pie gets smaller, the table manners change. And
15 I think the phenomenon that's happening to physicians is
16 forcing them to look for opportunities to replace income.
17 That's different than the typical conversation that you would
18 have about supply and demand. So, I think you have to look
19 at what the driver is.
20 The final point I would make is that there's a
21 temptation, I think, when you look at competition in health
22 care to set up the classic model of Hospital A versus
23 Hospital B. But I think in this conversation you have to
24 widen the lens and the frame broadly enough to see the total
25 impact of the community. There are hidden costs in this and

1 you can't find them by just examining A versus B. For
2 example, if we disturb this delicate cross-subsidization that
3 takes place in every hospital, whether it is a good one or a
4 bad one, cross-subsidization exists and it's how we provide
5 care to our communities.
6 Our community's expectation for our performance as
7 community hospitals is increasing; it's not declining,
8 particularly since 9/11. The expectations for our hospitals
9 to be prepared for virtually everything is increasing. And
10 that balance is very fragile. It's impacted by -- we listed
11 some of the things today -- by a shortage of labor, by new
12 technology, and by the preparation for bio-terrorism.
13 So, if you take away those profitable services and
14 leave the hospital, the community hospital, with just the
15 unprofitable services, one of two things is going to happen.
16 Either services will be diminished to the community in a way
17 that is not transparent, in a way that they cannot see that
18 happening, or costs will be shifted back to other payors, and
19 business and labor and consumers end up absorbing them, once
20 again, not in a transparent way where they can see what's
21 happening.
22 So, the consumer doesn't really get to vote in
23 this. They really don't get an opportunity to say A versus B
24 produces value for me. And I think the value equation is the
25 piece that we really have to take into account.

1 MR. BERLIN: We haven't heard from you folks down
2 at the end. How about your views on this?
3 PROF. FRECH: Okay, I think the comments just made
4 by George made a lot of sense. I think you think of basic
5 research that shows that more competition leads to lower
6 prices and lower costs among hospitals. And that's the good
7 news and the bad news. It's the bad news because it reduces
8 the profits for cross-subsidization. And that's a process
9 that has been going on as hospital competition has gotten
10 freer and more open for the last 30 years. It continues.
11 I would just like to suggest that this cross-
12 subsidization that the U.S. uses as a way of funding
13 uncompensated care and other services is itself not such a
14 great idea. For one thing, it's very opaque. It's very non-
15 transparent and it's wildly variable across areas. So there
16 are cities where it works great, you know, really efficient
17 hospitals are making enormous monopoly profits on one group
18 and just subsidizing all kinds of wonderful things on the
19 other side and access is real easy, even if you do not have
20 insurance. Santa Barbara is like that, where I live.
21 There are other places where it doesn't work for
22 beans and it's very opaque. It's a very poor way to run a
23 railroad, I think.
24 MS. LESSER: Yes, I would echo those concerns
25 about the cross-subsidies that we rely on. I think that it's

1 not a question that we need to have a way to finance
2 essential services in communities, but there are a number of
3 inherent problems in relying on cross-subsidies as the
4 strategy to do that.
5 I wanted to come back to some of the capacity
6 issues that were talked about just a moment ago. And I think
7 it really is an open question of whether the type of capacity
8 that's being added with the single-specialty facilities will
9 help or hurt the current broader capacity problems that we
10 have in communities. And, again, this is through the actions
11 of both the firms that are establishing independent
12 facilities and the actions of the community hospitals in
13 response to that. So, we're seeing a lot of investment in
14 the build-up of these specific specialty services at the
15 expense of investment in other areas, whether that be
16 specific services that are in demand, such as emergency
17 services, or just investment in infrastructure to promote
18 more efficient throughput in hospitals.
19 And our analysis in the past two years, looking at
20 this issue really closely, is that the throughput problems
21 are more of the problem than are the bricks and mortar
22 issues. And there are questions about the sort of syphoning
23 of attention to these specific specialty services, where
24 profits are leading everyone's attention, how much that's
25 really diverting resources from the broader capacity

1 constraint problem. And that's something that we'll have to
2 watch over time.
3 It was noted earlier that there is the potential
4 that this activity is actually exacerbating the nursing
5 shortage and the increased wage rates that are needed to
6 attract skilled nursing labor today. And certainly that
7 could be a cost contributor.
8 And then you have the issue of just adding bricks
9 and mortar, which, as I mentioned earlier, is really very
10 rarely taken out of health care markets, that we're creating
11 an increasingly inflexible system that has the risk of
12 increasing costs over time.
13 MR. BERLIN: Dr. Morehead, I see you have your --
14 DR. MOREHEAD: Yes, and I'd like to just make a
15 comment first of all about cost and then about quality of
16 care. And I'll just speak from the OhioHealth perspective in
17 Columbus, Ohio. The major problem, in our opinion, in
18 Columbus is not lack of beds; it's lack of personnel. We
19 don't have all of operating rooms operating or functioning at
20 a given time. We can't keep them going as long in the day
21 because we only have enough nurses and surgical techs and
22 that sort of thing to do the one shift. So, again, we need
23 to solve that problem first and then decide is there a
24 capacity problem or not, at least in our particular
25 community.

1 Quality of care, I want to certainly agree with
2 George. The whole -- and I appreciate the work that MedCath
3 has done, and I really want to emphasize, we need to continue
4 to do good studies. But the whole issue of quality is really
5 in its embryonic form, and let me just give you one of the
6 examples. I think you all at MedCath have done some
7 objections, or spoken to some objection, at least the last
8 time you and I talked in terms of peer review and that kind
9 of thing.
10 And I appreciate your willingness to give me a
11 copy of that article, but even if you accept that all the
12 methodological problems have been solved, if you look at the
13 risk adjuster, the ARP-DRG, the value of that, the accuracy
14 of that is only at about a .42 level, which means 60 percent
15 of these differences cannot be handled by that particular
16 program, by that particular risk adjustment program. And
17 what that generally has meant in the past is we have to do a
18 lot of studies to see if we can find a real trend that would
19 demonstrate.
20 So, I'm not arguing that there's going to be a
21 difference in quality or that the single-specialty hospitals
22 won't do a great job. You all have a lot of good physicians
23 and I think you will, but I think it's too early for us to
24 know exactly where the quality of care button will be pushed.
25 MS. MATHIAS: Dennis, I think you had a response

1 to that?

2 MR. KELLY: I appreciate that. Dr. Morehead and I
3 had a chance to sit in the National Airport one night and
4 talk a little bit about this. You know, when you look at the
5 efficiency argument, I mean, you talk about the efficiency of
6 the physician, the efficient use of the labor pool, and, you
7 know, looking at length of stay data, does give you some
8 measure of that. Looking at the number of patients a
9 physician can treat in a given period of time in
10 cardiovascular care, and as I said, we have a very, very
11 narrow focus as far as looking at the data and trying to
12 understand the impact of the operation.

13 You know, there will be 500,000 patients diagnosed
14 with congestive heart failure this year. There are some
15 studies that suggest that the current number of physicians,
16 cardiovascular cardiologists specifically, that we have
17 trained in the United States, will need to see twice as many
18 patients as they're currently seeing today in 10 years. So,
19 you know, they're going to find a way to be more productive
20 or we're going to have a much bigger crisis on our hands as
21 the population continues to age.

22 With the nursing pool, I mean, it's fascinating,
23 there is a shortage in every community in the United States
24 right now. We do not pay above market rates. In Dayton,
25 Ohio, presently right now, we have 14 nurses on a waiting

1 list to join our staff at our hospital because nurses like
2 working in this environment where it's not bureaucratic,
3 there are not a lot of layers of management to deal with,
4 they know where they're going to work every single day, they
5 know they're going to take care of basically the same patient
6 they took care of the day before. And that has a dramatic
7 impact on patient care and quality.
8 So, when we talk about quality, I completely
9 understand Dr. Morehead's concerns about the APR-DRG risk
10 modifier. All we can promise you is that when Lewin has used
11 that scale and when other people have used that scale they
12 use it for the entire population of Medicare discharges. It
13 is based on discharge data, so some of the things that occur
14 while the patient is in the hospital does go into that risk
15 modifier, but it's as good as we've got out there, and so we
16 have relied on that and we will continue to do so. But I
17 think we have complete agreement on the issue of releasing
18 more quality data.
19 MS. MATHIAS: One of the issues that we've been
20 addressing, that has come up again in these questions for the
21 panel, is the issue of cross-subsidization.
22 UNIDENTIFIED SPEAKER: Cost shifting.
23 MS. MATHIAS: Cost shifting, thank you. And as
24 the Department of Justice and FTC look at this we are partly
25 looking at it from the role of monitoring competition. Is it

1 really an area that we should be concerned about? I mean,
2 clearly we need to make sure that costs are paid for, but is
3 that a concern of competition or is it a different type of
4 concern that needs to be addressed elsewhere?
5 Go ahead, John.
6 MR. REX-WALLER: I think the issue of cross-
7 subsidization is an interesting one and I don't think that
8 you should be concerned with that in terms of the effects on
9 competition. I mean, another way to look at it is if you
10 flipped that on its head. The hospitals, it could be argued,
11 are taking the only service that is provided by a specialty
12 hospital, and in order to compete, offering that at below
13 market and probably cost in some cases. And we know that
14 that happens, because we see some of those contracts. So,
15 you end up cross-subsidizing some of those services. Now, if
16 offering services at below cost in order to compete, you
17 know, if Japan does that with steel, we slap a tariff on
18 them, and so I'm not sure that -- that's how it might affect
19 the competitive argument.
20 I mean, we've seen some per diem, some surgical
21 per diems, that are $1,000, $1,200, which is clearly below
22 cost. I mean, DRG 209, which is the replacement of a hip or
23 a knee; I think HCA or Solutions have done some studies
24 recently where the average cost is about $12,000. Medicaid
25 pays $9,000 to $10,000 for that. We can do it for $9,000 to

1 $10,000. And if the hospital is costing it out at $12,000,
2 I'm not sure that you can.
3 MS. MATHIAS: George, I think you raised your tent
4 next.
5 MR. LYNN: Thank you. I think it's important to
6 understand the cycle in terms of how the cross-subsidization
7 begins because we have focused on it today, but remember that
8 the government acts as a price setter for health care.
9 Medicare sets the rate and Medicaid follows, and those rates
10 are typically below cost. And if you look at how community
11 hospitals deal with that, I believe 13 out of the last 15
12 years the cost of living increase, to use layman's terms, has
13 been less than inflation. So, there isn't an ability for a
14 hospital to be able to make up on volume what begins with a
15 shortfall.
16 Secondly, then the government mandates behavior
17 for a community hospital through EMTALA and other regulations
18 that say, "And by the way, you must take all comers." In
19 most communities, in most community hospital settings, that
20 is in step with the mission of the hospital. The mission of
21 the hospital is to care for the needs of the total community.
22 What happens, as this pressure increases on the
23 ability of the community hospital to deliver to this very
24 broad set of expectations, it shines the light on the cross-
25 subsidization. It shines the light on those services that

1 produce a profit to offset those that lose. So, it is the
2 system itself. And that's why, as you take a look at the
3 proliferation of specialty hospitals, you tend not to find
4 them in certificate of need states where the government is
5 playing a role. To take a look at the broader impact on the
6 community, and you tend not to find them in specialties that
7 are inherently unprofitable. You don't find freestanding
8 trauma centers; you don't find, as was mentioned before,
9 children's hospitals and others, because they don't produce a
10 profit.
11 So, I think to take the light away from cross-
12 subsidization you would really need to reform the entire
13 system. It's the hand of cards that hospitals are dealt.
14 MS. MATHIAS: Cara?
15 MS. LESSER: I guess I would just add to that by
16 saying that I think that this is an important -- it is an
17 important component of what should be considered in
18 competition policy around these types of facilities, because
19 I think that if we are looking to specialty facilities to be
20 pro-competitive and to help to bring down the price of these
21 services, then we have to look at what the implications are
22 in terms of the loss of that profit margin and how we will
23 finance other services.
24 So, I think that from a government agency
25 perspective in understanding the effects of competition, that

1 that's an important element in terms of protecting consumers
2 in the story.
3 MS. MATHIAS: In order, Dennis, Dan and then John
4 again. And then we'll move to another question.
5 MR. KELLY: I just want to speak to the cross-
6 subsidization. And there are two aspects to it, actually.
7 There's the Medicare/Medicaid and versus, well, okay, they
8 don't pay you enough, so therefore we're going to charge the
9 balance of your payor mix the difference to try to cover the
10 cost you need.
11 In our case, you take Medicare as someone alluded
12 to earlier. In some cases, Medicare is the best payor in
13 some of our markets. So, whether we like it or not, when 63
14 percent of your patients are Medicare patients, you're going
15 to get paid what Medicare pays you, and that sets the
16 benchmark.
17 The challenge, candidly, when you look at the
18 cross-subsidization of other services is: How do you balance
19 "we need to do it" versus "it's so incredibly inefficient to
20 do it this way?" I mean, the problem you have is you end up
21 adding. As you add more businesses to an existing business,
22 the scale of the business, it gets very large and
23 unmanageable. And we respond as human beings to that by
24 adding more controls in place in the form of leadership and,
25 you know, systems and things of that nature.

1 So, the efficiency index of that method of
2 providing a broad set of care delivery is that you become
3 very, very inefficient. You add administrative and
4 supervisory costs. You add clerical costs. You now have
5 this thing called a transportation department because the
6 buildings are so large you have to have a staff dedicated to
7 moving equipment and people from point A to point B.
8 MR. MUHOLLAND: Sort of like the Federal Trade
9 Commission. I saw your van outside. I think that cross-
10 subsidization is relevant in another sense and that's to the
11 extent that a single-specialty hospital were to challenge a
12 full-service hospital's response to its presence in the
13 market on anti-trust grounds. The cross-subsidization
14 argument, I think, goes a long way to justify the kind of
15 responses that we talked about today. For instance, the
16 attempt at getting a preferred relationship with a managed
17 care company is a legitimate and reasonable and pro-
18 competitive response to the building exclusivity of the for-
19 profit single-specialty hospital.
20 In terms of the staff privileging disputes, if the
21 hospital were the victim of further cross-subsidization
22 problems by virtue of cherry-picking of the physician owners
23 of a single-specialty hospital, then it would be reasonable
24 and justified, based on its community service mission for the
25 hospital to say, if you want to have staff privileges here,

1 you can't be admitting or referring an inordinate number of
2 indigent or non-paying patients to us and keeping all the
3 cream for your facility.
4 All these arguments would be relevant under
5 Sherman I or a rule of reason analysis in Sherman II
6 analyzing whether the conduct was predatory or was justified
7 by a reasonable business purpose. And I think the cross-
8 subsidization in many respects, both of the types that Dennis
9 talked about, are at the heart of why hospitals are taking
10 this action. It's not just to be mean to doctors or to get
11 even with somebody because they pull business away. It's
12 attempting to level the playing field, which is rendered
13 uneven by the ownership interest the doctors have.
14 MR. REX-WALLER: I think back to the question of
15 the cross-subsidization, specifically, is that I think
16 because we've got a reimbursement system that is screwed up.
17 That isn't a reason to maintain the existing inefficient
18 system. I think there needs to be new and innovative ways of
19 delivering health care.
20 And ultimately the reimbursement system, we hope,
21 is going to change and be modified to reflect a much more
22 efficient allocation of resources across the country. But I
23 think to say that the inefficient system that you have,
24 because of the reimbursement system that you have to protect
25 that old, inefficient system, is not the responsibility of

1 the FTC, as they should be encouraging new and different
2 mechanisms to deliver that health care. And the
3 reimbursement system shouldn't be coming into it.
4 MR. BERLIN: I was debating whether to ask another
5 sort of open-ended question that would certainly be the last
6 one today.
7 (Laughter).
8 MR. BERLIN: Instead I'll try to ask a somewhat
9 more targeted one and maybe we'll get in another question.
10 This one is for you, Mr. Kelly, and you, Mr. Rex-Waller. And
11 that is, what is your response to Mr. Muholland's statement
12 that the scope of the emergency room coverage provided by a
13 single-specialty hospital, to the extent it exists, is
14 somehow less than that provided by general acute-care
15 hospitals? I sort of wrote the question and then heard your
16 presentations. You know, do you think that your facilities
17 are unique? What I'd like you to do, if you can, is speak to
18 your facility but also, if you can, characterize, as you know
19 it, sort of single-specialty hospitals across the board in
20 making this comparison.
21 MR. KELLY: John, I'll go first.
22 MR. REX-WALLER: And we have different
23 perspectives on this.
24 MR. KELLY: Right, we do, we do. First of all,
25 I'll just -- the reason John commented -- made that comment

1 is we don't have -- I don't have knowledge nor experience of
2 what the other specialties are doing.
3 What I can tell you is the data that I showed you,
4 because I just pulled it again this week. One of the
5 advantages of being involved with multiple facilities, we
6 have 10 in operation right now, is that every month we can
7 look at the same data from every facility which, you know,
8 within -- which I spent my Monday looking at emergency
9 department statistics. And I shared that with you earlier.
10 Sixty percent of our visits, 59, 60 percent of our
11 visits on the trailing 12 months come to us and are non-
12 cardiac patients. You know, less than 3 percent of those we
13 have to transfer out to another facility.
14 The fact that only 24 percent of the hospitals in
15 the country have open-heart surgery and the fact that we have
16 relationships and transfer agreements, where hospitals
17 transfer to us, in rural America, which is mainly, you know -
18 - we're in urban settings, but we work throughout a region,
19 that they're really regional referral centers. We end up
20 having 22 percent of our admissions transferred in.
21 So, speaking on behalf of, you know, 600
22 physicians that work with us in our 10 facilities, we think
23 we're part of the solution to that crisis, not contributing
24 to the problem.
25 MR. REX-WALLER: Yes, I think we have -- the

1 nature of cardiac care is that generally you can't schedule a
2 heart attack. It's that they come, they need an emergency
3 room and people go to emergency rooms, and as Dennis had
4 pointed out, their emergency rooms receive almost 60 percent
5 of the cases coming through are non-cardiac.
6 What we have chosen to do is instead focus
7 ourselves on a particular specialty. We focus on elective
8 orthopedic and neuro-surgical cases. That's what we do,
9 that's what we do incredibly well, that's what we do very,
10 very efficiently. And our hospitals are set up and have the
11 services to deal with exactly that.
12 And, so, we have typically well patients coming
13 through that don't need emergency care. They don't need the
14 emergency room. We don't need a full-service E/R. In some
15 states, we're required to have it, and so we certainly have
16 it and we are subject to EMTALA. And all of our facilities
17 are general acute-care license, so we're subject to EMTALA
18 like everybody else. But I think that you have the -- we
19 offer the services that we need for our particular specialty
20 with the kind of cases that we've got coming through.
21 The example has been used of what happens if you
22 have a jogger out that runs past a surgical hospital and has
23 a heart attack and goes in and the only thing you do, 911. I
24 think that if you take that argument to its logical
25 conclusion, if you have a massive traffic accident outside of

1 a hospital that doesn't have a trauma center, what happens
2 there? Well, I'd say you'd probably transfer that patient.
3 You stabilize the patient, if they present and you transfer
4 them to a facility that has greater capabilities.
5 And, so, in the spectrum of things, if you
6 continue that argument, every single hospital, everywhere in
7 the country, and in fact every surgery center, everywhere in
8 the country, should have a trauma center. Well, that's
9 ridiculous. I mean, there is a certain amount of
10 specialization that is required, and you focus on those
11 particular areas that you do best, and you do that well and
12 you provide the services that you need there.
13 Not every facility in the country has a neonate
14 intensive care unit. Why not? Well, we focused on a
15 particular set of services that we do best and we have taken
16 that down and we focus on surgery, which we do exceptionally
17 well.
18 MS. MATHIAS: Eddie?
19 MR. ALEXANDER: I thought John had an excellent
20 slide earlier that shows how difficult it is to pigeonhole
21 what is a specialty hospital. And on that point, as far as
22 it pertains to E.D.s, E.R.s, our facility in Columbus,
23 without question, follows the pattern that John sets at
24 National Surgical Hospitals, but in Nashville we're building
25 a hospital that looks more like a MedCath facility in that

1 it's a full-service E.R.
2 Then we have three things under development, three
3 hospitals under development, where we don't have an E.R. at
4 all for a simple reason -- we have a hospital partner, and we
5 utilize their E.R. services. So, again, it just kind of
6 comes back to each facility is a little bit different.
7 MS. MATHIAS: Go ahead.
8 MR. BERLIN: Actually, I was going to take turns
9 on questions, but that's a segue into my next question. That
10 is, you know, we've heard that there are all -- from you just
11 now and sort of throughout the presentations that what we're
12 calling single-specialty hospitals follow a variety of forms,
13 across a lot of factors.
14 Is it possible to generalize, though, between a
15 for-profit, physician-owned, single-specialty hospital versus
16 what I'll call a more traditional single-speciality facility
17 such as a children's hospital or a rehab hospital or perhaps
18 one of the new generation of entities that are either
19 hospital joint ventures or hospital owned? Are there
20 differences between, well, first of all, can we distinguish
21 between the two? Is there a clear enough line? And are
22 there differences in one or the other's impact on, again,
23 costs, access to care or quality?
24 Go ahead, George.
25 MR. LYNN: That's a great question. I believe all

1 hospitals have missions. They're either explicit or
2 implicit. I think for most organizations they're explicit.
3 And if you look at community hospitals, you'll see a
4 commonality among missions that's remarkable. It's designed
5 to serve the needs of a community and the community is
6 defined in different ways. But the community, the
7 significant thing is the community has a big "C", it's not
8 exclusive, it's inclusive.
9 The mission of specialty hospitals are equally
10 valid but not the same, and I think it's important to draw
11 the distinction, as you just raised, between the two. In the
12 act of making a profit, the specialty hospital serves the
13 community with a small "c". It may be patients who have a
14 certain common disease: heart disease, orthopedics; or
15 certain patients who have insurance.
16 If you compare that narrower definition of
17 mission, the mission with a small "c", and compare it to
18 other organizations, like children's hospitals or psychiatric
19 hospitals, I think one of the startling differences that
20 you'll find is that even within the narrow definition of a
21 type of patient, you will find in those missions a
22 comprehensiveness, a taking all of the patients who suffer
23 from psychiatric disease or all of the children of a
24 community.
25 So, I think there are distinctions, and they're a

1 little subtle. They're not obvious, but I believe that the
2 existence, the opportunity for a company to joint venture
3 with physicians around narrowing that definition is only
4 effective because all of the other providers are treating the
5 community with a large “C”. If all of the providers in a
6 community were to adopt that same narrower mission, that we
7 will pursue profit by segmenting the market into profitable
8 segments, partnering with our physicians to drive volume.
9 You could make a catalog of all the unmet needs in
10 the community and it would be startling. And that, I think,
11 is what the community hospitals in this country are trying to
12 say -- that this is upsetting a balance that is invisible to
13 the people that we serve and it's incredibly complicated and
14 we ought to take care, as you are doing, to examine it
15 thoroughly and see the total implications of these decisions
16 on delivering health care to the community.
17 MR. KELLY: In regards to treating the large “C”,
18 as he's referred to the large community, I will tell you, we
19 would be ecstatic if we treated all of the heart patients in
20 a large community. We would expand our facility or add
21 another facility in the community to accomplish that and
22 accommodate it.
23 What we do treat, we don't decide who comes in.
24 We basically say that we are participating in a federal
25 program, that federal program has certain legal and

1 regulatory requirements that you must meet. Our partners
2 know it and we know it and we take them all. And the data
3 reflects it. The data shows that the level of Medicaid
4 patients, the level of indigents we care for come to our
5 facility.
6 And, you know, one thing that's interesting about
7 us as Americans, you know, we like to go to "the place that's
8 the best." And, so, as soon as you said you name a facility
9 a heart hospital, it's amazing once it establishes its
10 presence in a community, it is viewed by the community as the
11 best. And typically it's not the best -- for those that are
12 wealthy, it's the best.
13 So, we get everybody that comes in, and that
14 population of 100 percent includes those that can't pay. Our
15 physicians treat them; we treat them. It includes those that
16 have good insurance and, for the most part, as you saw, two-
17 thirds of the time it includes Medicare. I think they are
18 common, to answer your question. Where's the commonality?
19 The commonality is that a group of medical professionals have
20 deemed that's the best clinical environment in which to
21 provide care. They're different from the standpoint that
22 there is some economic driver involved.
23 MR. BERLIN: Dr. Morehead?
24 DR. MOREHEAD: Thank you. I'd like to speak to
25 that. I happen to be a pediatrician. I've done a lot of

1 training in children's hospitals and so I have a fairly
2 strong passion about why there are children's hospitals. And
3 I think it is a different kind of concept.
4 Pediatric hospitals came into effect because the
5 number of complications and unusual conditions are much
6 smaller in number than in adults. So, we need to get a large
7 number of specialists together with a large population and
8 that matches very well. And when a mother brings a child to
9 a pediatric hospital or anybody less than 18, for example,
10 they know that when they're there, whatever the problem is,
11 whether it's heart or kidney or lung or a combination of all
12 those, there's somebody there that can take care of it.
13 I think the problem with the single-specialty
14 hospital is you need to know you've got a problem with your
15 heart or you've got a problem with your bones or you've got a
16 problem with something else, because the real issue is for
17 those unusual or unexpected incidences, when somebody has a
18 problem with a bone but also two or three other problems,
19 then it's less -- the care there is less comprehensive and
20 less highly technical in terms of capacity than in the other
21 situation. So, I look at it as kind of a horizontal/vertical
22 kind of difference.
23 MS. MATHIAS: Cara?
24 MS. LESSER: I just wanted to add that I think
25 that a key -- from my perspective the key differentiating

1 factor for the specialty hospitals from the general, acute-
2 care community hospitals is physician ownership. And I think
3 as others have pointed out, this is not -- this is not the
4 first time we've had physician ownership in hospitals. It
5 doesn't mean that it's totally new under the sun. But that
6 does seem to be a common characteristic across these and is
7 central to the model that the specialty hospitals are
8 developing and it's something that the general, acute-care
9 hospitals have responded to with joint ventures. I think
10 this is a signal that this is sort of a key defining
11 characteristic, is that economic investment and the
12 participation and governance and design of the facility.
13 So, from my perspective, that's another key
14 difference, and I think the distinctions that Dr. Morehead
15 about the children's hospitals are also good ones.
16 MS. MATHIAS: This is for the panel, one of the --
17 and maybe the single-specialty hospitals will want to respond
18 first, or the people representing that voice. One of the
19 allegations that has clearly been raised is that the
20 hospitals are engaged in cream-skimming or cherry-picking,
21 and maybe, Eddie, if you could address this first, what is
22 your response to those allegations?
23 MR. ALEXANDER: Well, it's a little harder for me
24 to address that because our hospitals are all under
25 development.

1 MS. MATHIAS: The microphone.
2 MR. ALEXANDER: I'm sorry. It's a little harder
3 for me to address that because all of our hospitals are under
4 development. But I can tell you that, using Columbus as an
5 example, there are four separate physician practices that
6 have invested in our hospital. If you look at the amount of
7 charity care they provide within their practice as a
8 percentage of their net revenues, it's greater than any of
9 the hospitals in Columbus by a significant factor. It's not
10 even close.
11 And our physicians are on record as stating that
12 that same patient base that they see in their practice will
13 come to our hospital. We have no intention to not accept
14 someone strictly on the basis of them not being able to pay.
15 I don't think that's an appropriate stance in any way, shape
16 or form. And that's really where we are with that particular
17 facility.
18 In Nashville, we've partnered with one
19 particularly large orthopedic group. There are two large
20 orthopedic groups in Nashville. One does not take TennCare,
21 I think Dan referenced TennCare earlier. It's essentially --
22 it's Medicaid for us. And they don't take any patient that's
23 a TennCare patient. There's another group that's about the
24 same size that essentially sees all the orthopedic TennCare
25 in Middle Tennessee, that's the group that we've affiliated

1 with. So, those TennCare patients are coming to our
2 hospital. So, time will tell. This time next year, I'll
3 have the ability to prove that to you, as opposed to just my
4 hypothetical.
5 MS. MATHIAS: Dan?
6 MR. MUHOLLAND: I think it clearly is hard to make
7 a generalization about all of these hospitals, as everybody's
8 observed. But cherry-picking can happen a couple of
9 different ways, one direct and one indirect. The direct way
10 is if a single-specialty hospital either didn't participate
11 in Medicaid or had physicians who didn't participate in
12 Medicare and Medicaid, or if those physicians were still on
13 the staff of a full-service hospital, they would be able to
14 select where they were going to do a particular procedure.
15 That's why some of these credentialing responses can be
16 reasonable in terms of preventing that.
17 But there is an indirect way that you can cherry-
18 pick, and that goes back to the emergency facility issue
19 again. If you either have limited or no emergency
20 facilities, you're far less likely to get the kind of
21 indigent load that would normally come into a full-service
22 hospital through the emergency room. So, configuring a
23 hospital in a way to minimize your emergency responsibilities
24 will necessarily minimize any overall responsibility to the
25 indigent or people who maybe have less than favorable payment

1 mechanisms.
2 So, you know, it can happen either as a result of
3 design or as a result of the intent of the people who own the
4 hospital or may not happen at all, depending on the market.
5 MS. MATHIAS: Dennis, I think you flipped your
6 tent next.
7 MR. KELLY: I just wanted to comment on it very
8 specifically. We do not do that. The design of the
9 emergency departments, the design of the hospitals, the
10 structure of the businesses, everyone knows and, you know, is
11 widely discussed. We have a very strong compliance program
12 to ensure that there are the checks and balances in place,
13 just to ensure that if you come to our facility, whether you
14 didn't know what our focus was or not, and that's -- I think
15 the data speaks for itself. Sixty percent of what comes in
16 isn't cardiac to the emergency departments, and we can treat
17 it and we take care of it.
18 And as far as the economic cream-skimming, only
19 taking those that have insurance, I think it just -- when you
20 decide to deal with cardiovascular disease, you're going to
21 get, as I said, you know, a mixed bag of that population.
22 And we'll take the good with the bad.
23 MS. MATHIAS: Eddie, I think you're next, and then
24 George.
25 MR. ALEXANDER: Just a comment on Dan's comments.

1 If you accept economic credentialing as a reasonable response
2 to cherry-picking, my only comment there is why invoke
3 economic credentialing before you have evidence that
4 physicians, in fact, will cherry-pick. This is what has
5 happened to us in the Ohio marketplace. I just throw that
6 out for thought.
7 MS. MATHIAS: Thank you. George?
8 MR. LYNN: One comment about the future. We've
9 spent a lot of time today narrowing the focus and looking at
10 specialties, but I think we're looking at this problem from
11 the inside out. If you take a community point of view and
12 look back at the provision of care in a community, at least
13 in the communities that I'm familiar with, the call for the
14 community is to become more comprehensive, not narrower in
15 focus, broader in focus.
16 If you look at the first Anthrax case in the
17 United States, the patient didn't know that we would have
18 told that patient to go to a university center. They went to
19 the closest hospital. And, so, if the closest hospital is a
20 14-bed spine hospital... I think the community has a set of
21 expectations that we haven't explored in these discussions
22 and I think they extend to a more comprehensive suite of
23 services and a better preparation for a total set of needs
24 that present themselves. I think to ignore it creates a
25 danger, particularly as we try to prepare for the threats of

1 bio-terrorism in this country.
2 MR. BERLIN: John, I believe you were next.
3 MR. REX-WALLER: I think that those services can
4 be provided, and they don't have to be provided within one
5 hospital and one hospital only. One hundred percent of the
6 services do not have to be provided by one hospital, which is
7 where I think your argument may go. They can be provided
8 with a suite of services that can be specific, and I think
9 that the specialization in health care is a trend that is
10 ongoing and to try and agglomerate everything back together
11 again is just countering that trend, which --
12 MR. LYNN: Which I think the key point would be
13 integrated services, and what we've explored today are
14 services that are not integrated to perform as a system.
15 That's one of the -- I'm sorry to repeat that.
16 MR. REX-WALLER: But I don't think that
17 necessarily the integrated system is, in fact, the right
18 answer. I think that the specialized care does provide
19 overall a better service to the community.
20 And if we could just come back to the question
21 that you asked about cherry-picking. We do not discriminate
22 based on ability to pay. It's quite clear that we do not.
23 And another related topic that I think is sometimes brought
24 up is that once a specialty hospital opens, the surgeons that
25 are operating in that specialty surgical hospital then

1 decline to do E.R. coverage -- decline E.R. coverage.
2 We have 300, 400 physicians who are involved with
3 our facilities. We do not have one that has dropped coverage
4 in the E.R. because they have an investment in the hospital
5 or because they're associated with the hospitals. It is that
6 all of our physicians feel that they have a community
7 responsibility to cover the E.R., to cover the big "C"
8 community, and they do that by doing E.R. coverage. So, we
9 don't have any examples of that particular instance
10 happening. And I think that there is an assumed causal
11 relationship which I don't buy. It just -- I don't think it
12 exists.
13 MS. MATHIAS: One thing real quick. David, you'll
14 get to go next, but also, I'd like to give everybody -- and
15 it will take us a little bit past 12:15, I do apologize --
16 but give everyone about a minute to give any conclusory
17 comments. So, David, I know you had an answer to that, if
18 you could work in your conclusion, and then we'll start down
19 with Dennis and work it down this way. And I'll,
20 unfortunately, cut you all off at about a minute.
21 DR. MOREHEAD: Let me respond to why OhioHealth
22 moved now instead of waiting. Economic credentialing, we
23 think, is a very hazy kind of thing. We don't like the AMA
24 definition because we've been doing things that violate that
25 for years and nobody has ever questioned it. Why we did it

1 now instead of waiting to see what happened is that it is a
2 conflict of interest response, not an economic credentialing
3 response, and the conflict of interest is real once the
4 hospital opens. And that's why we did the bright line
5 instead of trying to be detectives and figure out whether
6 anybody's done anything wrong.
7 My conclusion, I've talked enough. Thank you.
8 MS. MATHIAS: Okay. Dennis?
9 MR. KELLY: I share a similar sentiment. Our
10 commitment and our focus is going to be continue to -- in the
11 communities we serve -- focus on what's best for the patient,
12 try to enhance the care delivery model on a continuous basis
13 and make the physicians -- help the physicians become more
14 productive and just be good stewards of Medicare dollars,
15 which is where a large portion of our revenue comes from.
16 You know, we think that the level playing field
17 does exist as long as people want to play by the rules that
18 are out there and we're committed to doing that. Thank you.
19 MS. MATHIAS: Thank you. Dan?
20 MR. MUHOLLAND: Just by way of summary, this issue
21 is not going to go away. It's happening in every community
22 in the country at one degree or another and it's going to
23 continue to evoke a lot of heated discussion. But I think
24 that from the standpoint of the community hospital, they not
25 only have the right, but the duty, to take appropriate steps

1 to protect their charitable mission. And while the for-
2 profit, single-specialty hospitals certainly have a right to
3 exist and to flourish if that's a good model, they shouldn't
4 complain if community hospitals compete back and take
5 reasonable steps to protect their charitable interests.
6 MS. MATHIAS: John?
7 MR. REX-WALLER: I think that we need to protect
8 competition and not competitors. We need to encourage new
9 and innovative systems of delivery in health care and not
10 snuff them out even before they've begun in an effort to
11 maintain, what I think is, an inefficient status quo.
12 And I think that now the competitive threat has
13 arisen once again, as it did 25 years ago with the ASC
14 industry, we find that the competition is once again, as it
15 happened 25 years ago, waving the patient care banner and the
16 conflict of interest banner, which I don't think is
17 appropriate.
18 We're not looking for new laws, new subsidies, any
19 changes to the market competition, other than just protect
20 competition and not the existing competitors.
21 MR. MATHIAS: Thank you, John.
22 Eddie?
23 MR. ALEXANDER: I'll echo something that Dan said
24 earlier. You know, I think we all ought to hang together and
25 in particular as it pertains to the reimbursement system and

1 the inherent flaws that have been well discussed today in
2 that system. I think that as we do that, though, let us not
3 sacrifice something that's better for patients just simply in
4 order to maintain the status quo.
5 MR. MATHIAS: George?
6 MR. LYNN: Thank you. I think AHA is concerned
7 about the ability of our member hospitals to continue to
8 provide safety net services to communities if profitable
9 services are taken out of the hospital and incentives for
10 physicians to refer patients to settings in which they own a
11 share continue to evolve in communities. And we appreciate
12 the opportunity to participate in this dialogue. It's a
13 complex issue, and as many a people have said, it really
14 bears more scrutiny.
15 MS. MATHIAS: Cara?
16 MS. LESSER: I don't think I have anything to add
17 to that.
18 MS. MATHIAS: Just a couple of clean-up things.
19 We will reconvene at 2:00. Right now -- we've been on
20 conference call so that other people who couldn't make it
21 here could listen in. We'll cut off the phone line now, but
22 we will pick it back up at 2:00. It's available. In the
23 future, if you're interested in listening in, feel free to
24 check our website, www.ftc.gov website, I think, has the
25 number. I don't think we've been -- we should probably also

1 put it on the DOJ website so it's available. Of course we
2 really love having an audience too, so if you can, spend the
3 time to attend. I think it adds to the panel.
4 Second, a quick plug, is yours open for the
5 public?
6 MS. LESSER: Yes, it is.
7 MS. MATHIAS: Do you want to give it?
8 MS. LESSER: Sure. We are sponsoring a conference
9 on single-specialty hospitals on April 15th, and there's
10 information about that on our website, which is hschange.org.
11 It's open to the public and it's free, so I would encourage
12 everyone to comme.
13 MS. MATHIAS: And, finally, if you brought cups or
14 trash in with you, if you wouldn't mind taking it with you.
15 It makes my job a little easier. Thank you.
16 **(Whereupon, a lunch recess was taken.)**
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24 **CONTRACTING PRACTICES**
25 MR. COWIE: Good afternoon. This is the

1 Contracting Practices session of the FTC/DOJ health care
2 hearings. We are going to start with speaker presentations,
3 moving from my right to left. At the conclusion of each
4 presentation, or rather at the conclusion of all of the
5 presentations, we're going to take a break and then follow
6 with questions. We'll start with Tom McCarthy of NERA. Bios
7 are in the hallway.
8 MR. MCCARTHY: Thanks, Mike. I'm pleased to have
9 been invited. I think these are important and impressive and
10 ambitious hearings. I suspect that they will have
11 significant effect on antitrust policy in health care, so
12 let's hope that today's roundtable can make a contribution to
13 that.
14 One of my roles is as a stage setter in this, and
15 I'm going to start by reviewing just a little bit of history.
16 Some of it's history you know, but I want to make sure we
17 understand why hospital contracting is changing, as well as
18 what is changing about contracting.
19 Now, some of this is a fairly stylized
20 presentation of history, but I'm going to try to get this
21 broad sweep of two decades of changes in health care done in
22 five to 10 minutes, so some of these trends that I'm going to
23 talk about won't look sensible to your locale, if you're
24 thinking of a particular city and a particular health care
25 market. I suppose that obligates me to suggest that almost

1 any case we discuss, whether real or hypothetical, will be
2 very fact-specific. So, please don't depose me on these
3 generalities I'm about to throw out in the next five or 10
4 minutes.
5 Not too long ago, meaning the last couple of
6 decades, we, of course, had rapidly escalating costs. I'll
7 try to remind you of this painful moment quickly. Most
8 people thought this was due to inefficiency in the insurance
9 markets, having to do with substantial moral hazard, too much
10 care being purchased and unnecessary care.
11 So, we got the hew and cry from the buyers. What
12 came in, of course, was managed care, HMOs, and very
13 importantly, the Federal DRG system. What went out for the
14 most part, not entirely, was cost-based reimbursement, paying
15 providers on a usual, customary and reasonable basis and most
16 regulatory solutions. Certificates of need still exist, but
17 it's substantially less. Rate setting is substantially less.
18 As a result, hospitals were forced to become more
19 efficient. They were faced with fewer admissions, falling
20 lengths of stay, and surgery and ancillary services moved to
21 the out-patient setting. Technology sort of facilitated
22 this, but also this movement drove the kinds of technology
23 that was developed.
24 There were also a variety of cost containment
25 strategies that were adopted, particularly through the supply

1 chain, group buying and the like. Anyway, hospitals found
2 themselves with a lot of empty beds. As a result, they
3 slowly made structural changes. And the change that you see
4 listed there are the ones that the agencies have concerned
5 themselves, many of them, anyway: horizontal mergers,
6 closures, bed reduction, systems were formed.
7 Also, buying of medical practices really is a form
8 of vertical integration. The increase in the service mix
9 that also occurred was in anticipation of handling these
10 global capitation contracts, where you'd be responsible for
11 all the health care. So, we had that sort of vertical
12 integration, as well as horizontal integration.
13 The result was excess capacity through this
14 period, even though they were in the process of adjusting,
15 and that created bargaining strength for managed care.
16 Importantly, the method of bargaining strength, the method by
17 which managed care got low prices was selective contracting,
18 including steering. And what steering meant is they could
19 keep prices down by negotiating discounts for delivering
20 volume.
21 Now, the antitrust authorities coming out of this
22 period faced a number of frustrations with hospital mergers
23 that were challenged but they did not prevail on. In part, I
24 think in retrospect, this is probably too sweeping a
25 characterization, but a lot of this has to do with the

1 insurance market being able to take off itself. We found
2 also some physician investigations, mostly about messenger
3 models and mostly about IPA behavior. Again, this is sort of
4 a way of doctors walking up to the line of how they could
5 effectively collectively bargain but not quite collectively
6 bargain.

7 And then, I would say in some sense the high point
8 of where the insurer was seen as the driving force in health
9 care, I think came with the Aetna-Prudential review by the
10 Department of Justice. And I say that because it gave us a
11 fairly narrow product market to consider. That meant that
12 monopolization as a claim, market share as a claim, was
13 easier.

14 It also raised a concern, a novel concern at the
15 time, that monopsony power might be an issue. And I think
16 the lesson to draw from that is that at least in Texas the
17 insurers were, if anything, getting too strong. So, in
18 effect, what we have is a period of time when the insurers
19 are in the driver's seat.

20 At the same time, there's a hot economy that is
21 encouraging the demand for freer access, and we've generally
22 come to call this thing the managed care backlash. The
23 important implication of the managed care backlash is that
24 the bargaining strength shifts to the hospitals. If we want
25 more choice, that means the insurers have to arrange broader

1 networks, fewer gatekeepers, and less risk sharing.
2 That means that managed care has more difficulty
3 steering patients. That also means there are fewer
4 opportunities for selective contracting, because you're
5 having to build that broad network. That leaves you with
6 fewer chances to get discounts in return for volume.
7 At the same time, the managed care organizations,
8 as part of the consumer reaction, are not managing care as
9 tightly, at least that's what I see in some of the folks I've
10 worked with. And in some areas, capacity has fallen. So,
11 what we have is increasing demand, decreasing supply, a
12 demand for more choice and therefore the bargaining strength
13 shifting.
14 What has been the hospital's response to this
15 newfound bargaining strength? As you might imagine, the
16 hospitals are catching up. They're catching up through
17 higher reimbursements. In my humble opinion, in many markets
18 it's more than justified. There have been a lot of years of
19 less than full cost reimbursements for some hospitals.
20 Secondly, less risk bearing, some of the contracts
21 have less risk bearing in them. And various other contract
22 provisions, like wanting to be paid case rates instead of per
23 diems or per diems instead of case rates, percentage of
24 charges for, let's say, premature babies that can be very,
25 very expensive. You don't want to take the risk on that, so

1 you ask to be paid percentage charges, things like that.
2 Now, let me emphasize, before I move to the
3 insurer response, that when I say there has been an increase
4 in bargaining strength, I do not mean necessarily that
5 there's an increase in market power in the following sense.
6 The range that a hospital -- if we think of a bargaining
7 range as to where the hospital would accept a price,
8 depending upon its negotiating strength, it's anywhere from
9 its average variable cost up to a monopoly price. What I
10 mean by that is if a hospital's cost structure is 50 percent
11 fixed cost, 50 percent variable cost, you can see that
12 there's a big range where your variable costs would be
13 covered, a price that covers your variable cost, all the way
14 up to a monopoly price. So, there's a lot of room to
15 increase your bargaining strength without necessarily getting
16 to monopoly prices. That's one important distinction.
17 Now, the insurer response, they've had to pay the
18 higher reimbursements, and secondly, they've passed them on.
19 That is, there have been substantial increases in premiums.
20 I think this is really for two reasons. One is what we call
21 a higher cost trend, the higher prices for providers, but
22 also you're no longer buying share. During the '90s, I think
23 there were many big insurers -- Prudential is a good example
24 of somebody who was hurt by this -- tried to buy market share
25 with low premiums and as a result put themselves in

1 financially precarious positions.
2 Still, I want to emphasize the insurers are not
3 defenseless. They have bargaining tools. And they have
4 existing ones and they’re trying to develop some new ones.
5 One of those tools is to play physicians off against the
6 hospital. This is particularly effective in what we would
7 call a carve out: Where if the hospital is trying to charge
8 too much, the insurer can say, "Okay, I will send my out-
9 patient surgery to your freestanding physicians surgery
10 center across the street."
11 There are still risk-sharing contracts with
12 physicians and budgets against which they work -- not in all
13 areas, and I think it’s decreasing in most areas.
14 Nonetheless, they want to keep those wherever possible
15 because that allows them to steer as well. There is another
16 technique where they punish the hospital seeking high prices
17 with a loss of business elsewhere. And this really comes in
18 the form of two kinds of carve-outs, at least most generally.
19 First, a service-line carve-out. If some hospital
20 says I want high prices, one threat is to say I will move the
21 hearts to the big tertiary teaching hospital, even in the
22 next city. Another is a geographic carve-out which says even
23 though you seem to have market power or some strong
24 bargaining position in market A, if you try to charge me a
25 high price, I will refuse to contract with your hospital in

1 location B.

2 Tiering is sort of a new concept for hospital
3 contracts, though it’s really not a new concept. You may
4 think of this as drug benefits. There are often tiers for
5 pharmaceuticals in your insurance coverage, but if you get
6 the generic it’s a very low co-payment; if you get the
7 formulary brand, product, then it’s a medium co-payment; and
8 if you get the brand name that’s not on the formulary, you
9 pay a very high co-payment.

10 Well, insurers are exploring applying tiering to
11 hospitals based on their relative expense that comes out of
12 the contract negotiation. They do this for a couple of
13 reasons. One, hospitals in -- I’m sorry -- insurers, in
14 response to the managed care backlash, are trying to set up
15 restrictive network options. That is, if they have to offer
16 every hospital in town as one product, which would then have
17 a high co-payment, and maybe two out of four of the hospitals
18 in town with the medium co-payment; and then if they had a
19 very restrictive, exclusive provider kind of network, you
20 would have the lowest possible co-payment. So, what they
21 want to do then is still be able to negotiate by threatening
22 to steer. Tiering is one way to get there.

23 There’s also what I call the nuclear deterrence
24 option, which I think we’ve seen a couple of times in
25 California. What that means is brinkmanship -- contracts get

1 canceled, hospitals don't cover their own physicians' people,
2 and sometimes the physician group is not covered and they're
3 all busy explaining to patients why they can't get care at
4 the price they used to get or the site they used to get.
5 The antitrust authorities will hear about this, I
6 think. I think probably rather than more focus on providers,
7 we have the hospital merger retrospectives. I don't -- there
8 may be some insurer merger retrospectives going on. I don't
9 know about them. Physician consent decrees in the FTC, for
10 example, the Napa OB/GYNs. And interestingly, I think a
11 novel approach, which is in the MedSouth advisory opinion, in
12 this case the FTC is considering new approaches to providers
13 in ways to control cost and increase quality. That is, non-
14 fully integrated, yet joint contracting is allowed. And, of
15 course, they're holding these hearings.
16 I think the antitrust question that comes out of
17 this is what, if ever -- or I should say when, if ever, does
18 this increase in bargaining strength become market power and
19 how might it manifest itself? One important aspect of the
20 whole competitive process, I think, is this historically
21 important phenomenon of the insurers becoming active shoppers
22 for health care as opposed to just passive claims payors.
23 This whole notion of steering and being able to deliver a
24 volume for a discount is still quite important.
25 The ultimate pricing discipline on providers,

1 though, I think comes from two sources. One of them is
2 employers, and that's largely through their supportive
3 insurers. If insurers begin to offer narrow network
4 products, will they buy them? But from the economist's point
5 of view, the old, reliable discipline is always expansion by
6 existing rivals or new entry. So, these are sort of the
7 highlights of what to look for.
8 Now, let me talk about two contracting issues.
9 One of them is selective and exclusive contracting; the other
10 is system-wide contracting, also known in some discussions as
11 full-line forcing. First, selective contracting. It's been
12 effective, as I suggested already, in holding down provider
13 prices. It's provider-driven. It's a very logical, economic
14 process of seeking bids and having people respond to those
15 bids.
16 The technique, of course, is the threat of
17 significant lost business, or significant won business, if
18 the discount is advanced. It requires having alternative
19 providers with at least some margin of capacity so that you
20 can play the bidders off against one another and it requires
21 some ability to steer the people to the low-cost alternative
22 that you've been able to contract with.
23 I would just point out that exclusive contracts
24 are really a subset of selective contracting, but it's really
25 the most effective way to aggregate a volume of purchases and

1 direct it to a given provider for a discount.

2 Now, usually the results are quite pro-

3 competitive. In fact, I think one could argue that they've

4 helped constrain costs. But there are definitely lawsuits

5 that follow. Excluded providers sometimes file them. The

6 typical claim is that you get an antitrust foreclosure,

7 anticompetitive foreclosure designed to monopolize the

8 hospital market, and as I'll show momentarily, I think the

9 economic logic of a lot of these claims is pretty confused.

10 What does a typical excluded provider claim look

11 like? Well, often it starts with a conspiracy with a big

12 insurer. And this is a buyer conspiring with a seller, which

13 is in and of itself pretty hard to prove. In order to make

14 the insurer conspire with -- I'm sorry -- the hospital

15 conspire with -- I said that backwards -- the insurer

16 conspire with the hospital, one possibility that's been

17 claimed is that there's predatory pricing, where, let's say,

18 the big tertiary hospital in town says we'll give you

19 predatory prices on primary and secondary if you contract

20 exclusively with us and foreclose our little rival across the

21 street. So, predatory pricing is one technique.

22 Coercive tying, where it says if you want access

23 to my high-level neonatal care, you must give me an

24 exclusive. That's usually a pretty overt act and is usually

25 pretty easy to discover. And, of course, there must be

1 sufficient foreclosure to drive out inefficient rival. All
2 of this requires barriers to entry or the strategy doesn't
3 work.
4 So, when might it be a problem? Well, you could
5 -- I think the answer is rarely. It's usually buyer-driven.
6 There's not much evidence of coercion in these things.
7 There's net savings to the insurer. And, again, the
8 mechanism of the foreclosure is usually questionable;
9 predation, tying, conspiracy. And, you know, whether the
10 foreclosure is sufficient, usually it's not. It's usually an
11 exclusive contract with just one insurer that's being
12 complained about. Similarly, barriers to entry are probably
13 not robust and recoupment wouldn't be possible under these
14 theories.
15 All right, let me turn to the issue of full-line
16 forcing or system-wide contracting. That kind of contract,
17 as I think most of you probably know, a hospital system says
18 it will sign, if you will, a take all -- a contract for all
19 the services in the system, including its related entities,
20 and in all the geographic locations that the buyer could
21 purchase those services.
22 Usually, there is no exclusivity involved;
23 however, inclusion is required. In other words, the insurers
24 can contract with other hospitals, but you have to at least
25 include all of the services offered by the system.

1 In some cases, though, I confess I get this more
2 from trade press than an actual example. Tiering may be
3 blocked; that is, if you're going to do this, you cannot then
4 steer people. You'll take a contract with all my hospitals
5 and you can't steer them, and carve-outs are sometimes also
6 forbidden.
7 What's the economic logic of this? Well, let me
8 go through a couple of possibilities. Fundamentally, this is
9 a tying theory. And that involves two products. So, we get
10 into things like geographic market issues that were discussed
11 yesterday. You have a market, let's call it market A; you
12 have a hospital in A with relative market power. Let's
13 assume they have market power, something to be proven,
14 obviously. And then you have a very separate geographic
15 market where the system also has another hospital, hospital
16 B. So, those are the -- and C and D and E, if we want to
17 talk about a bigger system.
18 In a tying theory, you need a tying product, that
19 is, essentially, the hospital or doctor services at the must-
20 have location. There are also the tied or forced products,
21 which are the services at the location that the insurer would
22 rather not contract with, given the alternatives that are
23 available at that location. As a threshold condition, you
24 know, Jefferson Parish and beyond, you need substantial
25 market power in the tying market.

1 There is the economic theory question, though,
2 about can you leverage market power from one market to
3 another. And the answer is it's fairly rare. It's fairly
4 hard to do. I'll come to that in a moment. Is there
5 evidence of coercion? Are there legitimate business
6 justifications? The evidence of coercion is, of course, that
7 the buyer is having to buy a mix of products at a higher
8 price than what they would prefer to buy and there's no
9 offsetting benefits such as higher quality, better service,
10 lower transactions cost, lower administrative costs.
11 What is the hospital's logic for this kind of
12 contract? Well, I think there's some relatively pro-
13 competitive logics and there are some questionable logics.
14 One logic is transaction cost efficiencies. If you're a 10-
15 hospital system, it's clearly easier to sit down and
16 negotiate once over 10 hospitals than 10 separate
17 negotiations. While that's important, I don't know how
18 significant that is as sort of an antitrust reason for
19 possibly raising prices. But that's a separate question to
20 analyze.
21 I think the bigger reason, and probably the main
22 reason for these kinds of contracts, is that the hospital
23 system wants to stay a player in every location. And you go
24 back to the cost structure of the hospital to think about
25 this. If there's a high fixed cost component to all the

1 hospitals, a patient in, let's say, market B who's been run
2 through your hospital out there, at roughly average total
3 cost some reimbursement, his average total cost, is going to
4 contribute substantially to your incremental profitability.
5 So, if you have multiple hospitals out there where you don't
6 have any argument about market power, you would like to see
7 them all included and generate incremental profitability for
8 your system by being sure they are included. So, this to me,
9 see, is probably the driving logic of a lot of these hospital
10 system transactions.
11 Now, there are some more questionable approaches.
12 One, maybe this is a way to avoid the threat of punishment by
13 a geographic carve-out. Remember, the geographic carve-out
14 is to say if you don't give me a good price at A, I will
15 refuse to contract with B, but now you're being forced to
16 contract with B.
17 Another issue has to do with this tiering issue.
18 Even though there is a contract, you're forced to take a
19 contract with B. You could steer them away from that
20 hospital if you had the techniques to do it, and it's what I
21 call, in the L.A. area, I call this the Cedars-Sinai problem.
22 Cedars-Sinai, as you know, is a very prominent hospital in
23 the Los Angeles area. If you talk to them, they will tell
24 you it's one thing to get a contract, it's another thing to
25 get a patient. So, everybody likes to list Cedars on their

1 panel because it’s a prominent hospital, but not that many
2 patients actually go to Cedars. There are steering -- there
3 have been in the past anyway -- steering mechanisms by which
4 the patient goes to the lower cost alternative. So, if you
5 had -- even if you had this sort of requirement to buy in
6 another market, to take a contract with hospital B, the real
7 question is can you steer around that contract?
8 There is a theory in economics that has some
9 importance here. It’s called the one monopoly power theory.
10 And think of the initial question as this: Why not, if you
11 have a monopoly or a market power in one location, why not
12 just charge the monopoly price at that location? Can you
13 actually take your market power in A and somehow move it over
14 to B? And the answer that the one monopoly power theory
15 gives you is not very often.
16 One possibility for doing that is a predatory
17 strategy. The predatory strategy would be used to actually
18 change the market structure. The idea would be you use your
19 monopoly power in A to require something else -- I’m sorry,
20 let me do it -- I’ll do it specifically as a predatory
21 strategy. You use your market power in A to help fund the
22 predation strategy in B. And by predatory pricing in B, you
23 drive out allegedly the competitors if you -- and the
24 parentheses matter here -- if you have a substantial barrier
25 to entry or reentry, than no new providers can come in once

1 you've driven the others out, so you end up with actually
2 being able to transfer a monopoly power in one area into a
3 monopoly power in another area. It's a strong assumption
4 that that's going to be possible. Well, I've already
5 addressed a little bit of what that means.
6 Let me -- these are the steps as to what you would
7 evaluate, and I think these will end up on the FTC website,
8 so I won't spend a lot of time with sort of going through the
9 analysis of each of these. These are kind of the analytical
10 steps. Let me go to my last slide.
11 And so the question now is, when would this be a
12 problem, full-line forcing? When might this be a problem?
13 And I want to say, these are sort of symptoms or signals that
14 there might be a long-run antitrust monopolization type
15 problem. It's a complicated issue. The facts about a
16 particular contract are going to matter greatly, but here's
17 sort of the sequence of things to consider. The firm, as a
18 threshold condition, has to have market power somewhere in
19 one or more relevant markets and they've got to use that as
20 the condition of the forcing. This is really a redundancy,
21 but it's important enough to understand; that is, you've got
22 to have a significant barrier to entry to block entry in the
23 tying market, because obviously the market power may be
24 transitory if you don't. The outcome is not buyer-driven.
25 The contracts preclude payors from purchasing the mix of

1 services they would otherwise prefer to purchase a la carte,
2 even if they had to pay the monopoly price at location A as
3 part of that a la carte purchase. And they can't do that at
4 a lower price, which is another way of stating that the
5 contracts have caused -- and I mean the contracts have caused
6 -- the current market prices for the whole package to be
7 driven above super-competitive prices.
8 Normally, this would mean a monopolization in the
9 tied market, as well, but I suppose it doesn't have to mean
10 that. There are other outcomes, but the package would be in
11 total at super-competitive rates, where it wasn't before.
12 A couple of very final thoughts here. I think the
13 question is in these full-line forcing or system-wide
14 contracts, is there a less anticompetitive alternative, and I
15 don't know that you can decide that these contracts are
16 anticompetitive until you go through all of that analysis.
17 But I think some of the issue could be diffused quite
18 quickly, or at least the sort of competitive danger could be
19 defanged with one controversial sort of change. And it's the
20 practice in this contracting that raises my antitrust
21 antennae most. That has to do with the refusing to allow
22 tiering.
23 First, it's not clear to me that that provision is
24 tied somehow to whatever the efficiencies are of the full-
25 service contract. But you can see what the effect is. It

1 takes -- it makes the insurer no longer an active shopper,
2 because the insurer then cannot steer when forced to take a
3 contract. So, what happens? The physician and the patient
4 choose where they will seek care. And as a result, when they
5 don't have any particular cost incentive then the least cost
6 alternative is not necessarily considered. So, it seems to
7 me that this is one area where I think a little nudge
8 wouldn't hurt.
9 And I guess -- let me just give hospitals their
10 due in sort of the last thought here. To give hospitals
11 their due on tiering, their argument against tiering is it's
12 unfair, that they may be high cost not because they're greedy
13 or inefficient; they're high cost because they're high-tech,
14 they're high quality, they handle a high, intensively acute,
15 ill patient load. And, therefore, to be put on the least
16 favored tier is unfair to them.
17 I find that argument ultimately unpersuasive. Two
18 thoughts about it. One would be that like going to a quality
19 restaurant, a fine restaurant versus a family restaurant,
20 consumers can pay for higher quality. But there are some
21 distortions that do come out of the tiering, if you don't
22 take into account the case mix differences. So, it seems to
23 me the insurers and the providers could sit down and do case
24 mix adjusted tiering or something like that.
25 Let me get rid of mine, and we'll take questions

1 during the roundtable. Thank you.

2 (Applause).

3 MR. COWIE: Next is Meg Guerin-Calvert.

4 MS. GUERIN-CALVERT: I hope I will prove here that

5 economists can be complimentary and not necessarily fungible.

6 What Tom has done is covered about one-third of my talk, so I

7 can move through the slides very quickly and hopefully focus

8 on a related set of issues. I want to echo his words that I

9 very much appreciate the opportunity to be here today.

10 I think that contracting practices, not just

11 system-wide contracting, but the developments, as Tom has set

12 out, in contracting are vital for all of us to understand

13 because they form the baseline in the set of mechanisms, both

14 in competitive markets, as well as markets that may have

15 problems, to understand how prices, quality and competition

16 are functioning in these markets.

17 What I'd like to do, just by the way of overview,

18 is to look at three basic things today. First of all, and

19 this again echoes Tom, what is important to us about

20 examining today in this set of hearings contracting trends

21 and practices? Second, what have those trends been in terms

22 of contracting? Particularly I think at issue are trends

23 between hospitals and payors. There's obviously another

24 whole subset of issues in terms of contracting between

25 physicians and payors that's also of great interest. But I

1 won’t touch on those today.
2 And then to talk about some of the specifics of
3 how one goes about evaluating some of the specific
4 contracting practices that are of concern, both from an
5 antitrust perspective but also in terms of from the payor
6 side and the hospital side as one is thinking about how to
7 set up contracts, what are the issues, the business
8 justifications, the business rationales on both sides for
9 particular kinds of contracts. There’s a whole area
10 developing in economics, looking at more institutional
11 contractual arrangements that builds on the work of Oliver
12 Williamson. This is an area, I think particularly in health
13 care, where it’s very complex.
14 I think just as a very properly overly simplistic
15 point, or as my 17-year-old would say, duh, it is the
16 mechanism in health care by which a very substantial
17 proportion of health care services are purchased and
18 delivered. Contracting and contractual arrangements,
19 particularly between commercial payors and hospitals,
20 represents a very substantial volume of business. I’ve used
21 in the second bullet point contracting in quotes because it’s
22 much more than the specific ultimate contract between a payor
23 and a hospital. As Tom mentioned, it’s a lot of mechanisms
24 that get used before the contract is put in place and after
25 the contract gets put in place that as economists we would

1 regard as contracting provisions.
2 And then lastly, the practices have changed a
3 great deal, so views and thoughts as to what was prevalent,
4 even as recently as three or five years ago, when some of the
5 health care cases were litigated, are fundamentally different
6 now. That's important, not only for thinking about
7 evaluating what is going on now in terms of assessing any
8 merger or practice, but particularly as one is doing
9 retrospectives. It's very important to take into
10 consideration, as Tom did, the kinds of changes that may have
11 resulted in what appear to be higher prices where the product
12 that's being purchased has changed and it's not as simple as
13 saying the price was 10 two years ago and now the price is
14 20. It may be that the product is fundamentally different,
15 and if you could adjust for product quality, the price was 10
16 there and in real terms the price is 10 now. And, so, that's
17 something that one needs to think about.
18 I think overall, to an economist and to all of us
19 who are concerned in terms of antitrust, I think the first
20 point is that contracts are an important mechanism by which
21 competition occurs in the marketplace. And one of the
22 perspectives that I would like to bring is you can best
23 understand how contracting practices work -- not by looking
24 just at the markets that have the problems, but looking at
25 the markets that don't, the markets that all of us would

1 consider, for whatever reasons, as competitive, because of
2 the level of structure or the nature of competition on the
3 payor's side, the level of structure, competition on the
4 hospital side, so that we can get an idea in an environment
5 that we would all consider as competitive, how are
6 contracting practices working there?
7 What I have found that is very useful is that
8 oftentimes, seeing how they work there or in pre-merger
9 contexts, gives you a great understanding as to why they may
10 also appear in other kinds of markets. But you can't look at
11 the second problematic markets in a vacuum.
12 As a third point, with any contract in any
13 industry, it's very important to try our best to understand
14 where did this practice come from? What's the rationale?
15 There are two parties, at least, to any contract. What are
16 the business rationales for specific terms and conditions
17 from both sides and not just from one side of the
18 transaction.
19 In quick review, because I think Tom covered a lot
20 of this: What are the elements of contracting; what is the
21 importance of those elements in terms of commercial volumes;
22 what was the contracting process; what are the terms and
23 conditions of the contract. We should look at how these
24 contracts get assessed before people enter into them ex ante
25 and then how they evaluate the profitability of them ex post.

1 And there's a rich amount of information sitting
2 both within the payor side and the hospital side as to why it
3 is that people abandon certain contracting types and come up
4 with new ones. And then I want to just reiterate the point
5 that Tom made, and I'll make it a couple of times. A
6 contract in a hospital environment means that you're in the
7 network. It is not a guarantee that a single person will
8 show up in a bed. It's not a guarantee that anyone will
9 purchase the service. And that, I think, is very important.
10 If we hang on a second here. Okay, let me just --
11 somehow I managed to hit end. Okay.
12 Again, the reason why contracts are important to
13 us is that virtually all commercially insured patients are
14 subject to some contract form. On average, more than 35
15 percent of the patients in hospitals in the United States are
16 commercially insured patients. And being in the network gets
17 you access to those patients; being out of the network
18 doesn't necessarily deny you those, but ends up being much
19 more complicated in terms of the likelihood that patients
20 will be coming in.
21 In terms of the contracting practice, what I'd
22 like to spend just one minute on, having spent a considerable
23 amount of time both on the payor and the hospital side, one
24 of the things that I have been struck by in the hospital
25 industry as opposed to a number of other industries, is the

1 amount of time that is invested by both parties to even set
2 up one of these contracts for in-patient services and out-
3 patient services, whether it's HMO, PPO or a fully
4 capacitated, full-risk contract.
5 There's a very substantial amount of time and
6 money that is spent by each of the two parties independently
7 trying to estimate what the price is that's going to be
8 charged or offered for every single line of service that's
9 being contracted and a lot of back and forth. It can
10 oftentimes take months to accomplish one of these contracts
11 and months to achieve renewal.
12 Several contracts that a hospital might have may
13 be single-year contracts. Others may more typically be
14 multi-year contracts. But one of the issues that comes up is
15 that many of these are not evergreen. They have renewal
16 dates, and well in advance of those renewal dates, the
17 parties need to determine and announce to each other,
18 typically in writing, whether or not they are going to embark
19 on the process of renewing the contract or whether or not
20 they're going to terminate it.
21 So, there's a substantial amount of resources that
22 just go into the very process of evaluating the contracts and
23 the contract's terms in making changes from one period to the
24 next. In addition, as we all well know, the vast majority of
25 hospitals do not have a single payor with whom they're

1 negotiating at a point in time. They are negotiating with a
2 large number of payors, many of whom have contracts that
3 terminate at different points in time.
4 If you augment that to a hospital that has -- or
5 system that has multiple hospitals, you can do your -- I
6 guess it was fourth or fifth grade math, exponentials, which
7 I was never particularly good at, to get an idea of how many
8 different dates you need to be dealing with.
9 The next part is obviously there are very complex
10 terms and conditions of contracts. When I started doing work
11 in the health care area, I had assumed, as in a lot of other
12 industries, that there was such a thing as a price per
13 service, that one could look at a per diem or a discount off
14 of charges, and get a relatively good handle on what the
15 price was that had been agreed upon between the payor and the
16 hospital, and unfortunately, for economists who like
17 simplicity, it is very, very different from that.
18 Issues such as stop-loss provisions, a great deal
19 of provisions that ex post can result in substantially
20 different actual prices being paid, are important forms of
21 negotiation and things that you simply cannot leave out of
22 the analysis when you're trying to compare prices, even
23 within a given payor, a given hospital, a given period of
24 time, much less across periods of time, in different
25 populations of enrollees.

1 If you are looking at a contract that has a higher
2 risk pool than one that has a lower risk pool, all else equal
3 as an economist, I would expect hospitals to be charging or
4 attempting to get different prices for those two pools.
5 That's a cost-based difference in price, not a non-cost-based
6 difference in price.
7 Something I won't spend a lot of time on,
8 something that was prevalent in many hospital markets three
9 or four years ago, was the presence of full-risk contracts,
10 where hospitals were taking on, with their physicians, full
11 risk of contracts. Many hospitals did very, very poorly with
12 these kinds of contracts. They found that they had
13 significantly underestimated the difficulty in managing these
14 kinds of contracts, in understanding the patient basis, and
15 in simply not having large enough volumes of experience
16 across marketplaces to figure out how to price these well.
17 And many essentially had to buy their way out of these
18 contracts by trying to induce the payors to switch to very,
19 very low priced HMO contracts temporarily until they could
20 then, at renewal time, move into a more sustainable HMO
21 pricing.
22 And as Tom mentioned, I won't spend any time on
23 what was prevalent a while back was a lot of very significant
24 volume commitments. Something also to think about in
25 contracting is what both the hospital staff and the payors

1 are doing is (depending again on the hospital, on the
2 hospital system, on the payor) is very sophisticated modeling
3 of the break-even profitability of particular contracts. In
4 principle, what both sides are trying to do is to get their
5 best possible handle on what is the patient base that a
6 particular payor could bring in a given metropolitan area to
7 the hospital. What is the likely mix of services, that the
8 frequency of use of those services, the kinds of costs that
9 they are going to impose on the hospital, and as a result, to
10 try to figure out exactly what sort of significance of risks
11 are going to be brought to bear, what kinds of significant
12 costs, and as a result, to try to model or estimate what the
13 price-per-service should be.
14 And then in terms of ex post, there's a lot of
15 assessment typically done about the time where contract
16 renewal goes on to see how well did we do. Where this is
17 particularly difficult is entering into a new contract with a
18 new payor with whom the hospital has no experience, that they
19 have to use other populations of people that they think are
20 comparable, but ex post may not turn out to be.
21 So, what we're seeing in the marketplace as
22 sophistication has increased, is a great deal of adjustment
23 in pricing as people have come to understand what is
24 sufficient to cover costs and what is not.
25 Trends, Tom has covered this. The one factor that

1 I want to mention is that I would agree completely that
2 tiering of networks has proven to be the second easiest and
3 most likely tool that payors are turning to, given that they
4 no longer operate in a world where there are broad
5 exclusivity options and where they are dealing with all-
6 inclusive contracts. I would differ from Tom a little bit
7 that there are, nonetheless, the standard steering mechanisms
8 that are different from tiering that are in place.
9 Tiering is structured steering, where you're,
10 again, either in the network or out of the network. It's a
11 blunt tool, it works well, but what we see in a lot of
12 marketplaces is you are in the particular tier, even if
13 you're in the highest tier or the lowest cost tier, the most
14 advantaged tier, and yet nonetheless there is active steering
15 of patients away to other hospitals that are in that tier, so
16 as to credibly threaten you will have fewer patients in your
17 beds, unless you give me a good price for inclusion in the
18 tier.
19 I think in terms of looking at system-wide
20 contracting, it really is a circumstance where you have
21 systems are multi-plant firms, like in a lot of industries.
22 There are payor systems; there are hospital systems.
23 Hospital systems are prevalent in almost every metropolitan
24 market. We often think of these systems that have 10, 20, 30
25 hospitals go across a state or even across state lines, but

1 there are two-hospital systems, there are five-hospital
2 systems. There are even, depending on the classification,
3 one-hospital systems.
4 So, system is a word that covers a whole array of
5 structures and types. And, again, to understand why we see
6 possible kinds of contracting I want to take a little bit
7 broader perspective. I think Tom talked very well at one
8 aspect of system-wide contracting. More broadly, what
9 system-wide contracting is contracting on behalf of multiple
10 hospitals at the same time. So, regardless of whether you
11 get to the point where every hospital is in a particular
12 payor's contract, recognize the task that the manager of a
13 hospital system has to go through.
14 One of the things where you could have a business
15 rationale and efficiency, which you see in many other
16 industries, is if you could simply get a given payor, if not
17 all of your payors, onto common timing of contracts. So,
18 similar to having a fiscal year, you have all of your
19 contracts for all of your hospitals, at least for a single
20 payor, ending on December 31st of a given year. You could
21 then start the process of renegotiation of a given payor all
22 at one time, six months, three months in advance of that.
23 And that is one of the things that I have seen both on the
24 payor side and the hospital side as an important rationale
25 for trying to have some form of standardization.

1 The second is, and we see this again in many
2 industries, development and application of best practices.
3 What we see both in general and also in terms of development
4 of IT systems is that if you are a multi-plant firm who has
5 experience in a lot of different marketplaces, if you have to
6 do budgets for a lot of different plants, you end up
7 understanding what's average, what's extreme, and what's a
8 variability. You have a much better sense of, on average,
9 whether the experience here is in terms of outliers or in
10 terms of the kind of risks typical of something that I have
11 to work with, or is it something that is a factor that we
12 really need to take into consideration across all hospitals?
13 You can improve budgeting, and you can improve costs, and you
14 can have possible savings on personnel.
15 Now, the concern has been raised, as Tom raised
16 it, that what may end up happening is that you force people
17 to have supra-competitive pricing. I think it's important,
18 first of all, to distinguish right away is the concern the
19 sense that, well, now everybody's in the network, so no one
20 has any leverage, or is it specifically a concern about
21 system-wide contracting?
22 I think the analysis needs to evaluate what are
23 the competitive constraints; what are the mechanisms, the
24 tools that both parties have; what has been the practical
25 experience; and, as Tom said, what are the market conditions;

1 what are the abilities of payors to discipline pricing? Even
2 though a hospital system may say, "I would like you to put
3 all of my hospitals in a given contract," (A) it's not
4 necessarily the case that patients end up at all of them and
5 that steering has been denied, so the prices may be
6 competitive for that reason.
7 Second, it may not be the case that the payor goes
8 along with it, or if they go along with it, that they haven't
9 gotten a great bargain. What I have seen in some practical
10 cases is where a hospital said, "Take everything;" and the
11 payor said back, "I really don't like this hospital and its
12 quality particularly much. If it's really important to you
13 for brand image, for system-wide image, then for me to have
14 both of those in, you need to cut me a deal in the following
15 ways." And overall, in order to accomplish a particular
16 goal, the hospital system caves in.
17 So, I think those are important dynamics to look
18 at. What are the tools, what are the compromises on both
19 sides, not just on one? So, what's the bottom line? I think
20 it's most important to look at why do we see particular
21 contracting practices develop? Particularly in competitive
22 markets and by systems with whom we have no concerns, what
23 has the evolution been and how much of it is a logical
24 response to marketing conditions? We need to look at both
25 sides, but most importantly, in any competitive analysis that

1 we do we need to take into account what are the competitive
2 constraints and the tool kits that are available to both
3 parties -- to attempt to get the best possible contract on
4 the hospital side, but very importantly, on the payor's side
5 to assure themselves that they have been able to get the best
6 possible deal and have continued to have the flexibility use
7 other hospitals as a threat? We don't need to see the threat
8 actually turn into an actual contract. In many cases in this
9 industry, a threat alone is sufficient.
10 Thanks.
11 (Applause).
12 MR. COWIE: Brad Strunk from the Center for
13 Studying Health System Change.
14 MR. STRUNK: Well, I, too, am delighted to be here
15 and I appreciate the opportunity to come here and speak with
16 you all about some of the issues, a lot of which you've
17 already been hearing about. It's actually the case you've
18 heard already from Margaret and Tom. They speak about some
19 of the trends in contracting, and that's actually a good
20 portion of what I wanted to talk with you about, so hopefully
21 we can move through that and I can perhaps provide some
22 additional market context to what's happening out there in
23 the real world with respect to this issue.
24 For the past five years, I've been involved with a
25 site visit project at the Center for Studying Health System

1 Change, which tracks a representative set of 12 markets
2 across the country. And we've been following this issue of
3 health plan/hospital contracting pretty closely. What I'd
4 like to do is just share some of the findings that we have
5 obtained from that set of site visits that we've been doing
6 for a while now. Hopefully, this will provide some more
7 context for all the things you've already been hearing about
8 today.
9 So, throughout the course of this presentation,
10 I'm going to discuss findings that relate to three main
11 points. One is the reimbursement rates to providers have
12 been growing at faster and faster annual rates for a number
13 of years now. The second point is that a few years ago we
14 observed a noticeable shift in the balance of power between
15 health plans and hospitals. In particular, hospitals
16 regained a significant amount of leverage over health plans,
17 and that leverage has facilitated their ability to seek rate
18 increases. I plan to take you through the shift and describe
19 some of the strategies and contracting practices being used
20 by plans and hospitals to gain the upper hand in
21 negotiations.
22 The final point is -- maybe something sort of a
23 very up-to-date finding that we have based on our most recent
24 site visits -- is that we're now seeing some signs in our
25 most recent round of visits, the last few of which actually

1 are still to be conducted, that the balance of power may
2 actually be shifting back a little bit towards plans. This
3 finding is preliminary, but I'll share with you some of the
4 reasons why we think that might be the case.
5 Just a quick -- let me mention some things quickly
6 about the Center. I just want to say that from our inception
7 we've been funded exclusively by the Robert Wood Johnson
8 Foundation. And our emphasis in our research is on health
9 care markets. I just put the website up here in case you'd
10 like to get more information.
11 As I said earlier, the findings I'll be presenting
12 today come from our site visit project. We do these site
13 visits to gain insights into changing market trends. As I
14 mentioned earlier, we visit 12 markets in total. These
15 markets were originally chosen through a random process and
16 we return to these same 12 markets every year, which gives us
17 the opportunity to follow the evolutions of the markets over
18 time. Our third round of visits were conducted from the
19 middle of 2000 to the middle of 2001. And as I said, we're
20 out in the field right now conducting our fourth round of
21 visits. So, we've been tracking developments in these
22 communities for eight years now.
23 When we go on-site, we conduct a large number of
24 interviews with a broad selection of local health system
25 leaders. You can see up here we conduct between 70 and 100

1 interviews with leaders of the health care system in each
2 market. And we triangulate the results, meaning we examine
3 an issue from multiple perspectives. So, when hospitals tell
4 us about their relationship with health plans, for example,
5 we also hear about that relationship from the health plans.
6 And we always do this before we say something about what's
7 happening out there in the market.
8 This slide shows the 12 markets that we visit each
9 year. You can see that they're pretty well dispersed across
10 the country and really reflect where the population is.
11 So, with all that as background, let me jump into
12 the findings. I'd like to start by showing you how hospital
13 prices, which is -- that is, unit price, reimbursement rates
14 have changed over the past eight years. What I have here is
15 data from the Bureau of Labor Statistics, Producer Price
16 Index for Hospitals. And please note that this excludes
17 reimbursements from Medicare and Medicaid rates. So, what
18 you're really seeing here is changes in prices for the
19 privately insured, largely the privately insured.
20 As you can see, hospital prices grew 4 percent in
21 1994. Over the course of the next three years, the trend
22 declined, first by a small amount in 1995 and then more
23 substantially in 1996. And in 1997, hospital prices were
24 growing by less than half the rate of 1994. '97 was,
25 however, the last year of a decelerating hospital price

1 trend. Since that time, and continuing all the way into
2 2002, annual rates of growth have inclined steadily. And you
3 can see that it really surged in 2002. Relative to the past,
4 it grew by 5 percent, that's the fastest rate of growth since
5 the BLS began tracking changes in reimbursement rates to
6 hospitals in 1993.
7 I'm showing you this just to illustrate, quite
8 simply, that something has changed out there in the
9 marketplace that's led to significant increases in what
10 hospitals get paid, and that's what I'll be talking about
11 through the remainder of this presentation.
12 The change I'm alluding to pertains to the balance
13 of market power and negotiating power between health plans or
14 hospitals. It's important to recognize that the degree to
15 which one has leverage over the other is quite dynamic and
16 shifts back and forth over time, sort of like a seesaw does,
17 which is what I tried to depict here.
18 Now, the forces that govern the movement of this
19 seesaw fall into two general buckets. Forces operating in
20 the external environment on all organizations and the
21 internally driven changes that organizations make as they
22 pursue their own strategic objectives. Both of these are
23 constantly evolving at the same time. Sometimes they both
24 favor one sector over the other; and at other times, they
25 form counter-balancing forces against each other.

1 A final force of play here doesn't actually work
2 to move the seesaw but rather governs how far it can move in
3 one direction. This is the community norms you see on the
4 left. Community norms simply refer to what is deemed
5 acceptable in a community. Bringing this back to
6 contracting, community norms govern how much an organization
7 can exercise its leverage to seek favorable terms without
8 being seen by the community as taking things too far.
9 This is particularly important for not-for-profit
10 organizations that are accountable to boards that are often
11 made up of local health system leaders. Communities vary in
12 this respect a great deal, so the bracket could get larger or
13 smaller.
14 Now, back in the mid 1990s, the contracting
15 environment really favored health plans. We just experienced
16 a number of very rapid health care cost and premium growth in
17 the late 1980s and early 1990s. Employers were looking for a
18 magic bullet to control costs, and they seized on managed
19 care and HMOs as that magic bullet. At the time, managed
20 care and HMOs were characterized by narrow provider networks,
21 various controls on utilization, such as preauthorization
22 requirements and gatekeepers and capitated payment
23 arrangements to providers, the risk contracting that's been
24 discussed already.
25 Seeing that managed care had the backing of the

1 employer community, there was widespread expectation among
2 hospitals that enrollment in HMOs would grow significantly
3 and the tools of managed care would eventually become a
4 normal part of their lives. As a result, many hospitals
5 agreed to discount payment rates to ensure they'd be included
6 in the plan's network, expecting that they'd be able to make
7 up the difference with increased volume. Recall that
8 downward hospital price trend during this period and this
9 environment was an important force driving that trend.
10 Naturally, hospitals undertook a number of
11 strategies to better position themselves in a managed care
12 world. The first was to push to consolidate themselves into
13 systems and networks. Much of the consolidation hospitals
14 engaged in was horizontal in nature, where multi-hospital
15 systems and networks were built up, often around a certain
16 flagship hospital in the community. But they also engaged in
17 vertical alignments with physicians. We've seen this less
18 prevalently in our markets, but in those communities where it
19 did occur, such alignments certainly have important benefits.
20 Another strategy hospitals have used to respond to
21 managed care is to brand themselves or build their reputation
22 and recognition within the community. A motivation behind
23 this kind of activity is to establish must-have status in
24 plans' provider networks. This kind of branding is often
25 done around academic medical centers, for example, but even

1 communities that lack academic medical centers have premier
2 institutions that are seen as highly desirable. The premier
3 institutions, whether or not they're academic medical
4 centers, are often the flagship hospitals in the multi-
5 hospital systems.
6 Finally, hospitals moved to solidify their
7 position in specific geographic sub-markets. This was
8 another way to establish must-have status in plans' networks.
9 It creates a situation where there are multiple hospitals or
10 hospital systems in one market, but they're far enough apart
11 that people in one part of the community tend to use the
12 system they're closest to and not the system that's further
13 away, unless the further away system has some highly
14 desirable services, or is well regarded for some services.
15 All of these strategies helped hospitals to
16 increase their leverage over plans, particularly when you
17 consider some of the changes in the contracting environment
18 that appeared around the turn of the decade.
19 Some of this has already been mentioned, but the
20 environment did change in a number of important ways that
21 really began to favor hospitals. The consumers became very
22 disenchanted with the tools of managed care and that
23 disenchantment coalesced into what has already been
24 mentioned, the managed care backlash. Patients did not like
25 the restrictions placed on them when they tried to access

1 care and they didn't like plans dictating what providers they
2 could see and couldn't see.
3 As a result, managed care plans largely retreated
4 from the use of these tools and began promoting less
5 restrictive products with broad provider networks. This was
6 a time when PPO products really started to become the largest
7 type -- in terms of enrollment, the largest product out there
8 in the market.
9 Also, the U.S. was experiencing unprecedented
10 economic growth, which drove down the unemployment rate and
11 caused labor markets to tighten significantly. And under
12 such conditions, it was essential for employers to offer
13 generous health benefits packages that appealed to employees'
14 preferences for broad networks and less management of care if
15 employers hoped to be successful in recruiting and retaining
16 workers.
17 Finally, around this time, new capacity
18 constraints did begin to emerge. We saw new capacity
19 constraints emerging in our markets, making hospitals more
20 willing to forego a contract with a health plan. This was
21 the outcome of both some capacity being taken out of the
22 system, in part due to some of the consolidation that went
23 on, and it was also due to the retreat from tightly managed
24 care, which led to increased demand for services.
25 Now, while all that was happening around the turn

1 of the decade, hospitals were certainly facing a number of
2 pressures on their bottom line. First of all, hospitals'
3 Medicare margins began to decline following the enactment of
4 the Balance Budget Act of '97, which, among other things, cut
5 Medicare provider payment rates. And this places significant
6 financial pressure on hospitals.
7 Also, hospitals faced pressures on their finances
8 from growth in their own operating costs. For example, there
9 has been a severe labor shortage for a number of years now.
10 And when nurses are in short supply, they're able to command
11 higher wage rates from hospitals. And, actually, if you look
12 at data on wage rates from the Bureau of Labor Statistics,
13 you can see a really significant increase -- really
14 significant acceleration in the growth in wage rates in just
15 the last few years.
16 There are other pressures such as the rapidly
17 rising cost of prescription drugs and hospitals in some
18 markets face a number of pressures that are specific to their
19 market. For example, hospitals in California face enormous
20 seismic retrofitting costs, as mandated by state law, to make
21 sure that their buildings can withstand an earthquake. These
22 are just some examples of the pressures that hospitals are
23 facing.
24 Now, all these forces I've been describing so far,
25 the strategies of hospitals, the changes in the external

1 environment and the pressures that hospitals are facing
2 coalesced to create a situation in which hospitals have
3 aggressively pushed for better reimbursement rates and
4 contract terms. Moreover, what we're seeing is that
5 hospitals across many of our markets have enjoyed a great
6 deal of success in securing better rates. And if you think
7 back to that figure on the hospital prices that I showed you
8 earlier, you can really see that borne out in that figure.
9 Hospitals are using a number of approaches during
10 negotiation to secure better rates. One thing we've seen in
11 many of our markets is a terminate-to-negotiate strategy.
12 Fairly early on in negotiations hospitals announced that they
13 wish to terminate their existing contract with a plan, or
14 that they don't intend to renew their contract unless their
15 request for higher rates and better terms is met. This helps
16 to raise the stakes of the negotiation.
17 Hospitals are also leveraging their system status.
18 In a few markets, for example, we've observed systems that
19 contain a highly reputable and desirable flagship hospital,
20 threatening to cut ties with the plan, unless the plan is
21 willing to contract with and provide favorable rates to the
22 other hospitals in the system, even if the other hospitals
23 are less desirable to the plan. It sort of gets at the full-
24 line forcing that Tom spoke about earlier in more detail.
25 We don't know if these less desirable hospitals in

1 the system are getting the same rates as the more desirable
2 flagship hospital, but it does appear, from what we can tell,
3 that they're getting better deals than they otherwise would
4 have if they hadn't been in the system.
5 We've also observed hospital systems that have
6 close ties to physicians using this solidarity in the
7 negotiations with plans. Again, this is less prevalent
8 across all markets than hospital-only systems, but where it
9 does exist, plans face significant risk if they fail to come
10 to terms with a hospital and also lose physicians in the
11 process.
12 Finally, we've been seeing hospitals appeal for
13 public support in many of our markets with contentious
14 negotiations. This often goes hand-to-hand with the
15 terminate-to-negotiate strategy. For example, a hospital may
16 notify its patients that they'll no longer be able to accept
17 their insurance if the plan doesn't come to an agreement with
18 the hospital.
19 Negotiations also get played out via the local
20 media, which further heightens the public's awareness of
21 what's happening. Plans, of course, use this tactic, as
22 well, but it appears that patients often identify with their
23 physician or with their hospital before they identify with
24 their insurance company.
25 The bottom line is that contentious contract

1 negotiations between hospitals and plans have become much
2 more commonplace in markets across the country, and
3 particularly the markets that we track. And this often
4 threatens or even creates, in some cases, significant network
5 instability for patients.
6 Now, health plans have been undertaking a number
7 of strategies in response to the gains in negotiating
8 leverage hospitals have achieved. Some of the -- Tom and
9 Margaret both spoke a little bit about this already, but one
10 response has been these tiered network products, and they're
11 usually products where patients have to pay a different
12 amount of cost sharing, depending on which hospital they use.
13 Now, we see these hospitals up and running, right
14 now, in only three of our 12 markets: Orange County, Seattle
15 and Boston. And they've reportedly caused some hospitals to
16 agree to lower rates to get into the preferred tier.
17 Nonetheless, we've also heard a fair amount of skepticism
18 about their viability. For one, providers in many
19 communities are clearly putting up resistance to these
20 products. We've heard, for example, that a few hospitals
21 that risk being in the high-cost tier have used their
22 leverage to assure placement in the preferred tier, without
23 agreeing to lower rates.
24 And in some communities that don't yet have
25 tiering hospitals have sought contracting language

1 prohibiting it. They also have -- there's also data
2 challenges to these products, not the least of which is
3 figuring out how to measure quality so that it can be
4 incorporated into the tiering criteria and we can certainly
5 debate whether or not quality is an important thing to put
6 in. If it is, there are a lot of barriers to getting that to
7 work.
8 Now, if these products are to represent a
9 significant challenge to a hospital's leverage, they'll need
10 to gain the kind of acceptance from consumers that drives
11 significant enrollment gains. And that does not appear to
12 have happened yet. But they are important to watch,
13 especially if enrollment in them increases significantly in
14 the future.
15 Plans are increasingly pushing payment incentives
16 tied to quality. While there are multiple motivations behind
17 this push, not the least of which is to simply improve
18 quality of care, these incentives can also be seen as a way
19 to place conditions on the rate increases sought by
20 hospitals. I wouldn't characterize this as a widespread
21 phenomenon, but it does appear to be gaining momentum in the
22 market right now.
23 Finally, a number of plans are beginning to look
24 at narrowing network products again, such as those built
25 around what's called exclusive provider organizations. EPO

1 products typically have the more narrow provider network, but
2 not the kind of utilization management restrictions that
3 characterized HMOs. The viability of these products is,
4 however, quite dependent on consumers' willingness to accept
5 a limited network of providers again. And we've seen that
6 for a while now they haven't been very accepting of that.
7 We've actually seen some recent situations in a
8 few communities where exclusive relationships between plans
9 and providers have fallen apart, or are showing signs of
10 falling apart. So, it's really unclear right now if plans
11 will have anything to gain from these EPO products.
12 As I mentioned earlier, the contracting
13 environment is certainly not static. In fact, we're now
14 seeing some developments that could send it back in favor of
15 plans. All the evidence so far indicates that 2003 brought a
16 third straight year of double-digit premium increases to
17 employers and employees. Meanwhile, employers' profits and
18 workers' wages are growing at a slower rate because the U.S.
19 economy, which went into recession in 2001, is still sluggish
20 and the combined effect here is that there's been significant
21 increases in health insurance costs -- even though I would
22 note that it's not quite as bad as it was during the
23 recession of '91.
24 Moreover, employers are moving to increased
25 patient cost-sharing. So, this really, you know, it effects

1 -- it shows the effects that are even larger than the
2 combination of large premium increases and the sluggish
3 economy would suggest. In this kind of environment, it's
4 possible to imagine a situation in which both employers and
5 employees become more receptive to products that offer, for
6 example, a narrow provider network, if products are cheaper.
7 So, let me just wrap up with an assessment of
8 where the balance of power between hospitals and plans stands
9 today. As we proceeded through our most recent round of
10 visits, we continue to see a willingness on the part of
11 hospitals to take their negotiations to the brink and use
12 some or all of the approaches I described earlier.
13 However, we've also seen some variation in the
14 outcomes of the contract showdowns we've observed. In fact,
15 there's been a few instances where health plans have been
16 able to hold the line on hospital demands for increases. In
17 the recent cases where the health plan had success in holding
18 the line they were able to do so in part because they
19 received greater support from the employer community for
20 their tough stand.
21 The situation is markedly different from two years
22 ago when employers choose to either stay out of these
23 disputes or quietly pushed plans to settle to avoid network
24 disruption. Now, this is, in part, a consequence of what I
25 was just describing before and it may also signal that the

1 amount of leverage hospitals have is coming up against
2 community norms.
3 Even if there isn't a renewed interest in narrow
4 network providers among consumers, this development, if it
5 continues, could be an important countervailing force on
6 hospitals' leverage. Nevertheless, we're seeing fewer
7 showdowns getting played out in the public, so it's more
8 difficult to determine who, if anyone, is coming out ahead in
9 these.
10 So, in closing, I think it remains to be seen
11 whether or not the balance of power will shift back in favor
12 of plans again in the near future and that's something we'll
13 certainly be tracking. Such a shift would indicate that
14 there continues to be countervailing pressures across the
15 sectors driving healthy competition in local markets. One
16 would expect such cycling to occur because the environment is
17 constantly evolving and health plans are constantly adjusting
18 their strategies in response to one another.
19 For policymakers concerned about competition
20 policy, such shifts in the balance of power over time provide
21 an important indicator of how markets are working and will be
22 important to monitor going forward.
23 Thank you.
24 (Applause).
25 MR. COWIE: Art Lerner of Crowell & Moring.

1 MR. LERNER: I am just going to stay here. I
2 first wanted to just make an observation about the minute-
3 word ratio. Mike told me that I get 10 minutes, and Tom had
4 25. So, that's really stacked, since those of you who know
5 me know that I can get in 40 percent more words in 10 minutes
6 than Tom can get in 25 minutes, so Tom really has a complaint
7 here, I think.
8 Coming to this today is sort of a back-to-the-
9 future kind of thing for me. I just had a birthday last
10 week, and my kids told me, with great subtlety, that I am now
11 playing with a full deck, if you can calculate how many years
12 that is, which then reminded me that the last conference that
13 the FTC had that I remember on competition in health care was
14 in 1976, when, if you do the numbers, I was at the FTC and
15 was playing with half a deck, but anyway. . .
16 (Laughter).
17 MR. LERNER: I should mention that my comments
18 today are my own and certainly I think most hospitals and
19 most hospital systems behave in ways that are not even close
20 to the edge and that are, you know obviously quite okay from
21 an antitrust standpoint. But that's not very interesting.
22 And, so, I'll be talking somewhat today about some of the
23 more interesting types of conduct, which, while across the
24 country we may see trends, as have been described in the last
25 remarks by Brad, some of the instances I'm talking about may

1 be some of the ones that are more on the vanguard of some of
2 these things, because those are the ones for which I get
3 phone calls.
4 Let me just mention some of the kind of practices
5 that I've heard about. Tom has mentioned some; Margaret has
6 mentioned some of these. Hospital systems demanding that if
7 you want the highly desirable hospital you have to agree to
8 contract with the rest of the system. We've talked some
9 about that, even if the other hospitals maybe aren't of the
10 same quality and reputation, that if you want to get a
11 contract with this hospital, you'll have to contract for
12 physician services for physicians who practice at this
13 hospital through a particular organization in which the
14 physicians have become organized; you can't contract with
15 physicians independently, and if you want to contract with
16 this hospital, you'll also have to contract with the
17 ambulatory surgery centers, DME suppliers or home-health
18 agencies that we own or are affiliated with at prices higher
19 than market prices for those services; that if you want to
20 contract with our system, you have to include all of our
21 hospitals in your highest benefit tier. And we've talked
22 about this tiering idea.
23 And certainly I think it's legitimate for a
24 hospital to say when I give you a discount, I want to know
25 what I'm getting in return for that. I shouldn't be at the

1 most extreme giving you a discount for preferred provider
2 status and then not be a preferred provider. I think that's
3 common sense. The issue, I think, becomes more acute when a
4 system says if you put any hospital in our system in the non-
5 highest tier status, you will be picking a higher price for
6 all of the hospitals. That's where I think the issue -- I
7 think picking up on a little bit of what Tom was saying, I
8 think becomes more acute.

9 Another practice is where otherwise independent
10 hospitals, not part of a single holding company, form a
11 network to adopt and pursue common clinical pathways, track
12 their performance against those measures and pledge, for
13 example, to give money to charity on an individual hospital
14 basis if the hospital doesn't hit the targets, but then use
15 this integration on a clinical front, as a basis upon which
16 to insist that they can engage in price fixing to all comers.
17 We'll talk more about that.

18 I've got a prepared statement that's outside that
19 goes into more detail on some of this, but in the interest of
20 time, we're going to skip through. One of the questions gone
21 into here is the question Tom posed about well, assuming one
22 has market power, and I thought it was an interesting -- this
23 question of being able to charge more than variable cost but
24 less than a monopoly price, when in that spectrum have you
25 begun to have market power is an interesting question, but

1 I'm going to assume for purposes of discussion right now that
2 somebody in the story has some kind of market power.
3 And I think it's appropriate to recognize that
4 there are gradations of market power. It's not like market
5 power is here and no market power is there. There are
6 gradations, I think, in the real world that what you might
7 see in some instances, and Brad, I think, gave you a flavor
8 of this, is a hospital might see an advantage, even if it's a
9 hospital that has some power already, in aligning a large
10 proportion of the local physician community with that
11 hospital by contract or by ownership. There may be very
12 legitimate vertical integration and quality improvement
13 advantages from this, but in some instances, it could have
14 anticompetitive effects.
15 Health plans often depend on physician behavior to
16 discipline exploitation of market power by hospitals. If a
17 health plan has a risk arrangement with the doctors under
18 which the doctors are partially at risk for the cost of
19 hospital services, the health plans can enlist physician
20 cooperation in admitting patients to less expensive
21 hospitals. However, if a hospital takes over the managed
22 care contracting function for a large proportion of the
23 community's physicians, then that aspect of the dynamic
24 between the managed care and those doctors can disappear.
25 The hospital might structure the doctors' reimbursement

1 arrangement so that they are insulated from the cost of the
2 hospital services, and they can also work with the physicians
3 to try to forestall more informal efforts by the health plan
4 to encourage utilization of other institutions.
5 When the number of physicians involved is low, of
6 course, this is not a problem. This becomes a problem only
7 as a matter of degree, as the number of physicians gets much
8 larger. In some cases, and this is where it gets even more
9 interesting, the hospital might be willing to use some of its
10 leverage as a hospital to get the health plans to get more
11 money to the doctors. This gets at this whole question of
12 using up your monopoly chips in one place and how are you
13 going to use them? You might conceivably see a hospital use
14 some power to convince a managed care plan to pay doctors
15 more, even if in some theoretical way it means that the
16 hospital might make less. But in a sense, what the hospital
17 might be doing is buying insurance, that it won't have to
18 reduce its prices even more if the doctors truly become
19 agents of competition, shopping around for and using their
20 ability to influence physician admitting patterns.
21 In some cases, you see the situation that was also
22 talked about where the hospital might insist on the managed
23 care plan including other hospitals, maybe elsewhere, or
24 other types of providers in the network at prices higher than
25 those institutions could otherwise command. And there might

1 be some of the legitimate business reasons that Margaret was
2 describing why this may be going on.
3 But it also may be that the health plans are, in
4 fact, being required to pay more in town B and higher than
5 competitive price in town A. In other words, the situation
6 that Tom was describing, where you could conceivably have a
7 situation where the net overall cost is more than if the
8 hospital simply charged a high price in the first town would
9 have some market power.
10 Why might this be the case? I don't know exactly.
11 It may be that it's the case because by transferring the cost
12 of these services to consumers in another town, you basically
13 get a different demand response. In other words, if one town
14 your costs are already very, very high, further price
15 increases may risk the employer community buying cheaper,
16 lousier health insurance packages and more small employers
17 not buying health insurance. But if you shift the costs to
18 another town, you basically are not as far along on the
19 demand curve in the other town. But I'm not an economist,
20 but I've talked to a bunch of them, and what I got back was
21 two of them saying, "Yeah, that sounds pretty good;" two of
22 them saying, "Gee, I'm not really sure." So, I think there's
23 further study that's needed on this one.
24 Well, what should the antitrust enforcement
25 agencies be doing about this? First, I think there's a

1 couple of basic things that need to be remembered. One is
2 the per se rules have value. Number one. Number two, the
3 rule of reason would not be the marketplace equivalent of a
4 hall pass. And by a hall pass I mean that you're still stuck
5 in school but you're out of the teacher's reach. And too
6 often we're stuck in situations where you sort of have
7 clients that feel that well, gee, I'm in a rule of reason, I
8 guess that means they really can't get me. And I think we
9 have to remind people that that's not the case.
10 More substantively, I think that we need to -- I
11 would encourage the agencies to pay critical attention to all
12 the component parts of joint venture analysis, when they're
13 looking at provider and other joint ventures. For example,
14 not only whether the joint venture will achieve efficiencies,
15 but whether the joint venture -- such as the clinical
16 pathways one I described before -- whether there is any
17 logical nexus between the joint venture and why the
18 participants in the venture need to engage in price fixing.
19 As for the geographic and product market and
20 market power questions which underlie all of this, I can do
21 no better in the time we have today than to mention the
22 recent real-life anecdotal example, and I know it's only
23 anecdotal. A hospital executive told one of my clients,
24 according to the FTC, we don't have market power, but you
25 know we do.

1 (Laughter).

2 MR. LERNER: So, we'll be demanding a much bigger
3 price increase this year and you know we're going to get it.
4 This was right after they'd had a merger with a neighboring
5 hospital and they got the increase. I think there has been a
6 lot of attention posed on the geographic market issues and
7 hospital mergers. I think Meg's point about how the markets
8 have changed in the last couple of years, I think it's an
9 interesting question. I think the markets had already
10 changed a couple of years ago. I think when those cases were
11 being decided, the markets had already changed and that we're
12 always a little bit behind the curve in catching up.

13 We'll skip some of this stuff here. I wanted to
14 talk a little about the tiering idea. We already talked
15 about it some. I think the main point to recognize there is
16 that that's a tool, it's not a solution. If there's no
17 hospital competition, you won't get very far with tiering.
18 Okay? If there's only hospital or one system, tiering isn't
19 going to do anything for you.

20 So, you start with the notion that tiering is a
21 tool to try to take advantage of what level of competition
22 there is remaining in a market area. If the hospital system
23 has enough power and is savvy enough, they can defeat a lot
24 of tiering strategies through some of the things I've talked
25 about in terms of prohibiting it. They can also prohibit

1 some of the more informal steering techniques by basically
2 prohibiting it by contract.
3 And there may be a price tag associated with doing
4 that. So, I think tiering is a useful tool, but it's not by
5 itself a solution to a market power problem. I would be very
6 concerned, though, about hospital systems that basically use
7 the threat, not of taking hospital "A" and charging a higher
8 price if it's going to be in a lower tier, but of basically
9 saying we're going to give you higher prices across the
10 entire system if you put any of our hospitals in the lower
11 tier.
12 In terms of legal analysis, I think tie-in
13 analysis is a useful point of reference. I think you do run
14 into the economic theory question about, you know, whatever
15 monopolists only being able to extract their monopoly rents
16 once. And we run into situations where health plans perceive
17 that they're paying more, hospitals believe that they're
18 getting more, but the agencies are trying to figure out as a
19 matter of theory how and why this could be so and seeking
20 empirical data to prove that it's true.
21 I think we need to figure this out fast, and if it
22 is true, we maybe shouldn't spend too much time trying to
23 figure out why it's true. But if we find that it is true, we
24 should probably stop that harmful conduct if we can.
25 Some of this I've already talked about. Tie-in

1 analysis isn't the only screen. I think monopolization and
2 agreement and restraint of trade doctrines, of course, are
3 also highly instructive and all of you may not have yet had a
4 chance to read in full or even at all the Third Circuit Court
5 of Appeals en banc decision this week in Lepage's v. 3M
6 involving the market -- very analogous to health care -- of
7 Scotch tape. In any event, the critical aspect of that case
8 that I think one would want to look at is the Court
9 confirming that bundling price terms and bundling discounts
10 across different products to the same class of purchasers
11 can, at least on the facts in that case, be anticompetitive
12 and monopolistic. Even where the seller had not charged
13 below cost on the one hand or threatened an outright refusal
14 to do business on the other.
15 The other comment in terms of merger enforcement
16 I'd make -- in terms of enforcement is of course merger
17 enforcement. If we stop in the incipiency, mergers before
18 they create a market power situation, with sensitivity and
19 recognition of efficiencies and other benefits and also
20 recognition that market dynamics may shift again, but if we
21 stop anticompetitive mergers, then we don't have to deal
22 sometimes with trying to -- how to cope with market power
23 after it's already there.
24 And there are, of course, two sides to every
25 story, and I sort of had my role today to pitch one side, so

1 I'm not pitching the other side today, and I won't try to
2 argue why some of these hospitals' conduct might be good or
3 why they might -- and how the market might be self-
4 correcting, but I do think that antitrust must play a
5 critical role in policing the marketplace to ensure that
6 competition and consumer choice are protected. I think this
7 applies to provider conduct; it also applies to payor
8 conduct, which I know is a topic for next month. I wouldn't
9 want it to be felt that just because today we're talking
10 about hospitals it means that there's nothing to talk about
11 with respect to payors. But that's next month.
12 But I do think that while the circumstances where
13 a real case is necessary might be rare, and on the panel we
14 might not all agree about how rare. I think we would all
15 agree that it's probably uncommon that there would be a need
16 for an enforcement action. I think there is definitely a
17 need for an enforcement presence here because I suspect, I
18 suspect, and I have reason to think that in some
19 circumstances that people are crossing the line.
20 (Applause).
21 MR. COWIE: I think we're going to jump to Harold
22 Iselin at Couch White, and then Vince Scicchitano of Vytra.
23 MR. ISELIN: Thank you. My name is Harold Iselin.
24 I am counsel to the New York Health Plan Association. The
25 New York Health Plan Association is the state trade group

1 that's made up of over 31 health plans ranging from large,
2 national health plans such as Aetna, Oxford, Cigna, to
3 medium-sized regional plans to smaller plans that serve
4 primarily Medicaid and Child Health Plus, and we even include
5 managed long-term care plans, so we have the full gamut.
6 As you might imagine, these plans, health plans,
7 often don't agree on much, but if there's one thing they do
8 agree on, it's the tremendous concern they all share over
9 what they perceive to be anti-competitive conduct on the part
10 of many hospitals and hospital systems in the state. The
11 practices the health plans have experienced run the gamut,
12 including many of the ones already mentioned. To take a step
13 back to the most basic problem, we see naked price fixing.
14 I'm not just throwing that out as a provocative thought
15 because fortunately we have the court decision in the Vasser
16 Hospital/St. Francis Hospital case that many of you may know
17 about, which granted summary judgment and reflected a fairly
18 naked example of price fixing done under the excuse of "well,
19 the government said it was okay."
20 We also have more subtle examples of price fixing
21 done through virtual or pseudo-networks, including a fairly
22 common tactic of what's been talked about before, that you
23 must include every hospital in the system. That's not the
24 exception; I think that's the rule in New York. We have
25 pseudo-networks where there are virtually no operating

1 efficiencies or no clinical integration. We also commonly
2 see coordination and communication over prices through shared
3 counsel, through trade associations or through other
4 consultants. Again, where people have tried tiering or
5 floated it, it's common that it is outright refused.
6 We've seen quite a bit of brinkmanship, which Brad
7 talked about, including all of the examples, termination as a
8 prelude to negotiation, ads in newspapers, et cetera, et
9 cetera, which are among all of the other marketplace issues,
10 also trigger quite a number of regulatory problems when that
11 tool is invoked. So, we see all of these problems, all
12 through the state, but nowhere are they more prevalent than
13 on Long Island.
14 And with that, I'm going to turn it over to Mr.
15 Scicchitano, who's here from one of our member health plans,
16 Vytra Health Plan, who can talk a little bit more
17 specifically about the unique problems experienced in that
18 market, which I think also are going to raise some of the
19 issues about geographic markets which are alluded to but
20 which present themselves in the unique fashion on Long
21 Island, given its geography.
22 MR. SCICCHITANO: Thank you. And I'd like to
23 thank the Commission and the Department for the opportunity
24 to speak today. Being from a health plan, I'll no longer be
25 able to get a job in the hospital market on Long Island. And

1 I didn't bring any overheads, not to leave any evidence of
2 being here.
3 (Laughter).
4 MR. SCICCHITANO: I'm the Senior Vice President of
5 Vytra Health Plans, which is a Long Island Health Plan. I
6 joined Vytra in 1992 and have negotiated all of the hospital
7 contracts for the organization. Vytra is a not-for-profit
8 health plan with about a little over 200,000 members, 130,000
9 insured and 70,000 self-insured primarily in Nassau and
10 Sufolk Counties on Long Island.
11 My remarks today will focus on two ways that
12 hospital practices are adversely affecting Long Island
13 consumers and employers. First, the current system of
14 contracting has a negative impact on the percentage of Long
15 Islanders that are able to purchase affordable health care.
16 And, second, Long Islanders are paying higher rates to
17 support more hospitals than the marketplace needs.
18 On Long Island and across the region, we've
19 experienced four consecutive years of double-digit increases.
20 The cost of health insurance has risen at a rate several
21 times higher than the rate of inflation. For the past two
22 years, hospital increase alone have risen at a rate more than
23 three times the general inflation rate.
24 In order to fully understand the implications, I
25 need to spend a little time quickly just discussing the Long

1 Island market. There are approximately 2.8 million people
2 living on Long Island, and when I refer to Long Island, I'm
3 talking about Nassau and Suffolk Counties. Of the 2.8
4 million, about 500,000 are in government programs, such as
5 Medicare, Medicaid and Child Health Plus. There are about
6 350,000 to 400,000 uninsured on Long Island, which leaves
7 about 2 million people with health coverage through managed
8 care indemnity organizations.
9 Long Island is dominated by small businesses.
10 There are 90,000 companies on Long Island, with 80 percent
11 having less than 10 employees. None are in a dominant
12 position to dictate to the market. There are 10 health plans
13 on Long Island. No one has more than 20 percent share of the
14 market. Seven plans, including Vytra, have market shares
15 between 8 and 19 percent.
16 This has changed little over the years. What
17 really has changed is the hospital environment. Going back
18 to 1995, there were 27 hospitals in Nassau and Suffolk
19 County. When I negotiated rates, I negotiated individually
20 with each hospital, and decided which to include and exclude
21 in our network. We could negotiate favorable rates for
22 specific services by driving volume into preferred
23 arrangements.
24 Today, there are 25 hospitals in Nassau and
25 Suffolk, with 21 of them grouped into three health systems.

1 I apologize, I don't have a map, but I'll leave it up here
2 afterwards to see. But there's North Shore LIJ Health
3 System, which the Department has had some interactions with
4 in the past. They are predominantly on the western end of
5 Nassau and Suffolk. Then there's the LI8, which is made up
6 of eight hospitals. Then there's LIHN, which has some
7 hospitals on the western end of Nassau/Suffolk but really
8 controls the center of Long Island. And then there are three
9 hospitals on the east end of Long Island that control that
10 entire market.
11 There are only four independent hospitals
12 remaining on Long Island. As you will see from the map,
13 there is little overlap between the coverage. A health plan
14 needs all three hospitals in the system in their network to
15 be a viable competitor in the market. What's happened is the
16 hospitals are leveraging their authority to negotiate on
17 behalf of the system. And the two overarching themes from
18 the hospitals is health plans must negotiate with the system
19 and cannot negotiate with individual hospitals. And health
20 plans must contract with all the hospitals in the system,
21 unless it's to the betterment -- unless it's to the system's
22 betterment not to.
23 To further illustrate, there are three examples,
24 and they're not in any particular order except they're in the
25 same order as I went through the systems. One health system

1 requires that we contract with all of their hospitals except
2 one. And the one that we don't have to contract with is in
3 the northernmost part of Nassau County. There's nothing else
4 around; it's impossible to get to.
5 If you can't use that hospital, it's possible to
6 get around, so they've allowed us not to contract with that
7 hospital, which will only do discount off charges, for the
8 most part. So, it's not practical. We need the hospital in
9 our network. It's very honorable, but we can't really --
10 there's not much of an opportunity for the health plan to
11 leave the hospital out of the system.
12 The second system requires that we contract with
13 all the hospitals but won't let us contract with one of them.
14 It's a specialty hospital that has an occupancy rate over 100
15 percent and it feels no need to give discounts; however,
16 they're part of the health system. What happens is the
17 physicians send members to that hospital through the
18 emergency room. So, we're paying full charges for all of the
19 activity at the hospital.
20 And third health system, on the east end, notified
21 a local paper that Vytra -- well, they had terminated its
22 relationship with Vytra, which was not true. This initiated
23 calls from the Department of Health and other regulators,
24 asking how we were going to meet our access standards in the
25 region. In fact, it was not true, but, however, it did

1 initiate negotiations and resulted in increases in the rates,
2 which was off-cycle.
3 The reality is to compete effectively on Long
4 Island a health plan needs all three systems in its network
5 to meet the service and access standards, as well as customer
6 demands. If we don't contract with a particular system, the
7 plan will be unable to serve the significant portion of the
8 population. This dynamic affects consumers, employers and
9 health plans by severely limiting competitive pricing
10 opportunities that are normally available, such as requests
11 for proposals, carve-out agreements and provider agreements -
12 - and preferred provider agreements.
13 It also limits efforts to improve the quality of
14 care members receive by preventing health plans from making
15 greater use of centers of excellence. From this advantaged
16 position, the hospitals are proposing even more unreasonable
17 terms designed to bolster their positions. Let me give you a
18 couple of examples that I'll read exactly -- straight from a
19 contract that I have on my desk. "Vytra or Vytra's agents
20 shall not restrict by co-pay, deductible, pre-authorization
21 network design, plan design or any other method to prevent
22 access to the hospitals." Obviously, this is precluding any
23 kind of tiering arrangement, as well as other kind of
24 arrangements that may drive business from one hospital to
25 another.

1 The second clause, "If, as a result of any
2 significant change to any hospital's operating cost, the
3 hospital may propose a renegotiation of the rates." What's
4 the point of a contract if that's the case?
5 Third clause, "There shall be no carve-out of
6 services to subcontractors during the term of this
7 agreement." Now, that links all the ancillary services or
8 other services that we could go elsewhere. Physical therapy,
9 go outside of, get an arrangement, a capitated arrangement
10 with a physical therapy network, that would be beneficial
11 both from a quality and a cost perspective, we can't do that.
12 And the last, which I find the most interesting,
13 is, "During the course of the agreement, Vytra shall not
14 implement any policy, rule or procedure that reduces the
15 hospital's income." I don't know what that means, but I'm
16 sure it doesn't benefit the consumers.
17 (Laughter).
18 MR. SCICCHITANO: The impact of imposing these
19 conditions is that Long Islanders are paying higher rates to
20 support more hospitals than the market needs. The hospital
21 systems, rather than closing inefficient or underutilized
22 hospitals and beds, are causing consumers, employers and
23 health plans to pay more to sustain the status quo.
24 To date, our data does not demonstrate any
25 evidence of the clinical integration that one would expect

1 from a systems approach to the delivery of services. There's
2 been no measurable reduction in length of stay, while cost
3 for admission continues to rise at rates far greater than
4 overall medical inflation. And, now -- these are all
5 assurances that health plans had heard when these so called
6 mergers and acquisitions and alliances were formed. By
7 inflating the cost of health care, the current system of
8 hospital contracting does ultimately have a negative impact
9 on the percentage of Long Islanders that are able to purchase
10 affordable health insurance.
11 Thank you again for the opportunity.
12 (Applause).
13 MR. ISELIN: I just want to add one additional
14 point as a sort of New York State focus conclusion, and just
15 to show that we were listening. When Tom put up his last
16 slide, I wish we had it here again and could put it up. I
17 was trying to write the points down as I went, but as he went
18 through the points as to in the last slide of why we care or
19 when is it a problem, I forget what it was called, but every
20 single point that you listed is something that we have
21 present in New York.
22 We do believe that we have health systems with
23 substantial market power. I know that's probably a
24 discussion for later or another time. It's a complicated
25 discussion, but we think we could show it. We have enormous

1 barriers to entry. We do have a vigorous CON process,
2 applicable not only to in-patient but out-patient surgery.
3 There's a moratorium on out-patient surgery centers, for
4 example.
5 New York does not allow publicly traded entities
6 to enter those markets, so you have a very restricted form of
7 ownership structure that you'd have to adopt to get into the
8 market at all. Whatever is going on is not payor-driven. I
9 can't remember all the points, but I was checking it off,
10 and, again, we do have an across-the-board refusal to allow
11 tiering.
12 So, trying to tie what we're seeing in the real
13 world with your maybe 30,000-foot overview of what are danger
14 signs, if you will, we think they match up well. And I just
15 couldn't resist sort of tying back what we're seeing with
16 what you presented in a maybe theoretical way.
17 So, with that, thank you.
18 MR. COWIE: Next is Debra Holt, an economist at
19 the FTC.
20 MS. HOLT: Thank you. The contracting practices
21 that are under discussion in this session, or at least a lot
22 of them, bear some resemblance to models of full-line
23 forcing, tying and bundling. I'm going to discuss the ways
24 in which these models do and do not apply to the contracting
25 practices. I will also briefly discuss a bargaining power

1 model and some implications of a restriction on payors'
2 ability to steer patients to lower-cost or higher-efficiency
3 providers.
4 I'll start with the full-line forcing. Recent
5 economic analyses of full-line forcing focus on its use as a
6 vertical restraint to reduce a retailer to set the efficient
7 price when a monopolist produces multiple differentiated
8 products. In the single-product case, and with a monopoly
9 retailer, the efficient outcome is obtained when the
10 manufacturer charges the retailer a fixed fee and then sets
11 the wholesale price equal to the marginal cost of production;
12 however, when the monopolist is producing multiple
13 differentiated products, this instrument is insufficient.
14 However, a two-part price, combined with full-line forcing is
15 sufficient to obtain the efficient outcome.
16 Okay, so this take, this most recent take, on
17 full-line forcing has limited relevance to modeling the
18 potential anticompetitive effects of the contracting
19 practices that are commonly referred to as full-line forcing.
20 In the model, the manufacturer or provider has a monopoly in
21 both products. The goods in question are substitutes, and
22 the practice results in lower prices and higher efficiency.
23 However, there is one conclusion coming from these
24 models that is quite relevant to a consideration of remedies.
25 Namely, brand discounts, which could be interpreted as

1 hospital-specific discounts, is an equivalent instrument to
2 full-line forcing. And also, both volume discounts and
3 aggregate rebates are almost equivalent instruments to full-
4 line forcing. Therefore, should the sort of contract be
5 found anticompetitive, simply prohibiting the explicit
6 contractual terms may well not be effective.
7 There's an older literature that proposed a
8 leverage theory of full-line forcing. If those models can be
9 rescued from the Chicago critique, it is likely through an
10 approach similar to the Whinston-type tying model.
11 Let's see, tying I'll discuss next. Whinston,
12 among others, has developed a leveraging model in which some
13 equilibrium outcomes are counter to the Chicago tradition on
14 leveraging. In his model, a firm has a monopoly in one
15 market, the tying market, and also sells in an imperfectly
16 competitive second market, the tied market. The main result
17 of those models is that when consumer valuations for the
18 tying good are heterogenous and the two goods are
19 independent, then time can be profitable for the monopolist.
20 This sort of profitability can arise either
21 because rivals are made unprofitable and exit, or through
22 entry deterrence. This and similar models, however, are of
23 limited relevance, because the anti-competitive outcomes are
24 driven by the preferences of consumers over two goods that
25 will be consumed together in one bundle. Whether they are

1 complements or whether they're independent, the point is
2 they're consumed together. In contract, in the contracting
3 practices under consideration today, I think with one
4 exception, which I'll get to in a minute, a given final
5 consumer will use only one of these products, say, a
6 hospital. In addition, the tying or bundling under
7 consideration in today's discussion is only imposed on the
8 intermediary, not on the final consumers. So, as a result,
9 there's no obvious mechanism through which the alleged tying,
10 bundling or full-line forcing would negatively affect the
11 profitability of rival hospitals, reduce competition or harm
12 consumers.
13 Okay, so on to the exception, and that's related
14 to a model of bundling or tying with an intermediary by
15 Esther Galore. So, there are a lot of industries, actually,
16 where bundling or tying is prevalent and the products are not
17 sold directly to consumers, but instead to an intermediary
18 who may also have market power. One example given by Galore
19 in her model of bundling with an intermediary is health care
20 providers who bundle hospitals and physician groups and then
21 rarely sell that bundle directly to consumers. Instead, they
22 negotiate terms of payment with insurers and HMOs. And in
23 this model, the monopolist may find bundling profitable when
24 intermediaries have strong bargaining positions relative to
25 the monopolist. However, the bundling has no impact on

1 market share or competitiveness, because the intermediaries
2 have an incentive to offer consumers an optimal variety of
3 products.
4 So, the applicability to the full-line forcing
5 type contracting practices is limited since the tied products
6 in her model are perfect complements and the bundling
7 requirement is passed on through to final consumers. It may
8 possibly apply to some of the hospital-physician ties that
9 were referred to earlier.
10 Okay, the fourth thing I want to discuss briefly,
11 a bargaining power model. A model of bargaining power may be
12 relevant to the analysis of these contracting practices, as
13 has been alluded to. In a model by Chipty and Snyder, cable
14 franchises in discreet geographic markets negotiate with
15 programming suppliers over the terms at which programming
16 will be supplied. The result of that model is that under
17 certain conditions on the surplus function of the supplier, a
18 merger between the two cable -- between two of the cable
19 franchises can increase their bargaining power and thus their
20 profits.
21 It appears that the model's results may continue
22 to hold under the interpretation that the cable franchises
23 are hospitals and the programming suppliers are the payors or
24 the intermediaries. If this is the relevant model, then the
25 contracting practices are simply a means of increasing the

1 hospital's bargaining power. The result is a change in the
2 division of surplus between the payors and hospitals and
3 consumers are not necessarily affected.
4 Finally, I want to discuss sort of informational
5 issues. If the payors have better information than consumers
6 regarding the quality and cost of hospitals, then some of
7 these contracting practices may reduce the amount of
8 information available to consumers. And if so, you know,
9 there may be a loss of wealth there. There are certain
10 questions in this area that we need to get answers to; for
11 instance, what sources of information do consumers use in
12 choosing hospitals? Would a reduction in the ability of
13 payors to steer lead to overall higher health costs for
14 consumers; if so, through what mechanism? Would a reduction
15 in the amount of steering lead to less competition among
16 hospitals; and if so, through what mechanism?
17 Okay, so, just to summarize, we have existing
18 economic models of anticompetitive harm due to tying,
19 bundling or full-line forcing are of limited relevance. Not
20 only are the tied or bundled goods, hospitals in this case,
21 not complements, they are not consumed together at all, and
22 the hospitals are often not even in the same geographic
23 market. These facts are inconsistent with the methods by
24 which tying or bundling lead to an anticompetitive outcome.
25 Also, the tying, bundling requirements are thrust on payors,

1 not the final consumers. The consumers are getting, as a
2 result of these contracting practices, a larger number of
3 choices, along with possibly higher premiums. Can it be
4 shown that these changes harm consumers, given that the
5 change in price is accompanied by a change in the product
6 offering?

7 As I noted, the contracting prices are consistent
8 with the model in which the ownership of hospitals in
9 multiple geographic markets is used to increase bargaining
10 power and negotiations with payors. It is not at all clear
11 that such a shift in bargaining power would harm consumers.
12 If payors' coverage tiers are the only or primary mechanism
13 by which consumers learn about the desirability of a
14 hospital, then the restrictions on multiple tiering for
15 hospitals within a chain may reduce consumer welfare.

16 And, finally, assuming some anticompetitive
17 effects were found, the effects achieved through these
18 explicit contracting practices can most likely also be
19 achieved through various pricing schedules, including volume
20 discounts and aggregate rebates. Therefore, a remedy which
21 prohibits the explicit practices will probably not be
22 effective. On the other hand, a remedy that invovles
23 scrutiny of possibly equivalent pricing practices would be
24 problematic, given the number of efficiency justifications
25 for the pricing practices that might substitute for the

1 explicit contract terms.

2 (Applause).

3 MR. COWIE: Why don't we take a 10-minute break

4 and we'll conclude with questions.

5 (Whereupon, a brief recess was taken.)

6 MS. LEE: I have a question for the panelists.

7 Well, I have a couple of questions for the panelists to

8 begin. The first one is how has increased bargaining power

9 of hospital and hospital systems changed contracts? I mean,

10 we've talked about -- several people have mentioned that,

11 well, hospitals are now getting more money. But my question

12 is, well, how are they getting more money? Are they changing

13 from per diems to discount off charges? Are they now putting

14 MFNs into their contracts? How is it that these hospital

15 systems are getting more money?

16 MR. SCICCHITANO: All the ways you mentioned, but

17 basically it's just leverage that doesn't allow -- it's

18 really not a negotiation anymore. It's really here's what we

19 need. And they tend to be -- starting point, upwards of

20 around 15 to 20 percent, and you may negotiate certain

21 services off of that, but really when it gets down to the

22 fact that you can't exclude a system because you're dealing -

23 - at least on Long Island you're dealing with a whole system.

24 We can't exclude a system from our network without

25 losing some competitive advantage or at least staying with

1 the competition. It's basically take it or leave it in a lot
2 of situations. And they know -- when it was an individual
3 hospital you were dealing with, you could make decisions to
4 leave a hospital out of your network.
5 Yes, there were some implications to that, but
6 they weren't as dramatic as leaving out an entire geographic
7 area when you look at Long Island, saying we don't have a
8 contract there. The Department of Health in New York would
9 say, well, you can't -- you don't meet your service area
10 requirements. So, the hospitals know that, as well. They
11 know we can't terminate or allow a termination.
12 And then it runs -- you know, there is an example
13 on Long Island where Blue Cross came to a termination with
14 one of the health systems. It wound up in the newspaper,
15 battling back and forth. They finally settled, but it was
16 really more towards the hospital end of the negotiations.
17 MS. LEE: But do you see any trends? I mean, you
18 talked about in Long Island how there were three hospital
19 systems. I mean, do they tend to favor a certain type of
20 reimbursement or certain contract clauses, aside from the
21 full-line forcing that's been --
22 MR. SCICCHITANO: There weren't per diems. There
23 aren't per diems now, most of the situations, but they would
24 prefer to get the case rates, and then if there's any savings
25 there that may be available, they would like those savings to

1 accrue to the hospital by going on case, but they're taking
2 the current per diem experience to develop the case rates
3 that they would move forward with and then have inflation
4 factors off of those rates.
5 MR. LERNER: I should give another example.
6 MS. LEE: Okay.
7 MR. LERNER: You'll see sometimes changes where
8 the structure of the contract will stay the same, but there
9 will be a per diem, but then there's an outlier clause, that
10 if a particular case is a complex case, so that the costs
11 exceed the per diem -- or there might be a per-case, whatever
12 method there is, there's going to be an outlier cost. And,
13 so, what happens is there will be an increase negotiated in
14 the rate, but then there will also be a change in the outlier
15 clause, where the outlier cap may come down, which isn't a
16 factor or price increase.
17 MS. LEE: Right.
18 MR. LERNER: In some cases, the outlier kicks in a
19 higher level of payment once you've reached -- for only those
20 parts of the service that are after you've hit the per diem
21 cap. In other cases, then, they'll go back and start doing
22 it from day one. You'll also see changes in the whole
23 structure of the contract in terms of how quickly payments
24 have to be made, utilization review, and all of which you
25 might not say are wrong or right, but in other words -- but

1 they reflect a shift which, at the end of the year, ends up
2 being more cost to the health plan.
3 MS. LEE: Meg.
4 MS. GUERIN-CALVERT: I think -- two points,
5 because I think these contract terms are useful. First, one
6 of the things may be appro po, the two comments that were
7 just made, but particularly about the discussion we've all
8 had. One of the things that I think is really important to
9 understand is that one of the reasons why we are seeing price
10 increases across the board, if you look at, and I've done and
11 others here have done a very substantial amount of research.
12 Brad talked about some of it; Tom, I know, has done a lot.
13 If you look in every market in the country, costs are rising
14 at hospitals in substantially above the rate of inflation.
15 And as a result, it's not all surprising across the board in
16 every single market, at virtually every single hospital we
17 would see pressure to raise reimbursement rates, particularly
18 for commercial insurance, particularly in a world where
19 Medicare and Medicaid reimbursements, relative to costs, have
20 not quite kept pace.
21 And, so, if you look at studies of margins, a
22 greater proportion of hospitals are operating in negative
23 margins than were earlier and margins across the hospital
24 industries have declined in the last three years even though
25 reimbursements have gone up.

1 And I think the same thing is true of the
2 contracting practices. If you look, as managed care evolved,
3 there has been a movement as markets have matured from case
4 rates and simple discounts. New York has relatively recently
5 deregulated and moved first to just percent-off charges, then
6 moved to per diems. Some of the most advanced payors
7 themselves welcomed and encouraged case rates in Long Island
8 first. And, so, you see this evolution.
9 And just echoing Art's point, I have seen some of
10 the smallest hospitals attempt to renegotiate their contracts
11 because they found that both their outlier provisions, their
12 stop-loss provisions simply were not adequate to protect them
13 from the risks that they were having. So, I think it's very
14 important that all of us understand that these trends are
15 going on in all marketplaces. And then the issue is, in what
16 particular market circumstances do they raise a problem? I
17 just want to -- it's not the case just where you have
18 concerns about market power that you see increased rates of
19 reimbursement or particular new contract terms.
20 MS. LEE: Tom?
21 MR. MCCARTHY: Sort of a follow-up and
22 complimentary point that I think is that even if prices are
23 going up, and this is the point I was trying to make with the
24 wide bargaining range that a hospital could find itself in,
25 that even with prices going up, there is a big difference

1 between a hospital system becoming more profitable and an
2 anticompetitive harm.
3 And you have to trip -- the trip wire is some
4 measure of a monopoly price, and we can talk a lot about how
5 you might identify that, but the point I really want to make
6 is that it is not at all surprising that hospital rates have
7 gone up, particularly in New York, as Meg notes. New York
8 came off of regulation not that long ago. There was some
9 very unsophisticated negotiation that was going on for a
10 while. I think, if Rochester was any measure, I've done some
11 work in Rochester and in Buffalo, if they're any measures,
12 there was a scramble to try to figure out how you could make
13 sure you're going to keep the volume that you used to get
14 under the knife from the rate-regulated programs.
15 So, I think really what's going on now, I think
16 even nationwide, much less Long Island or New York, is that
17 the insurers and the hospitals are having to move toward a
18 new equilibrium. And I'm of the belief in general that
19 markets, health care markets, are actually fairly resilient.
20 That doesn't mean it feels good to be an insurer this week,
21 but that they're fairly resilient, and unless there's some
22 clear barriers to a competitive outcome, then I think you
23 have to let the process play out.
24 MR. SCICCHITANO: Just one point to add. I agree
25 that the cost trends are certainly up. The hospitals

1 certainly on Long Island are losing money. Part of that, the
2 inherent reason of that, is that there is an over-abundance
3 of beds on Long Island, and beyond the beds, there's an over-
4 abundance of services. You see two hospitals not far apart
5 from each other both adding PET scanners. Do you need two
6 PET scanners within two miles of each other? The supply
7 keeps increasing while the demand isn't there for it.
8 So, inherent in those increases they need, they
9 have to subsidize services that there's no demand for, at
10 least at this point in time. And it's not just with PET
11 scanners, it's with numerous other services that we see. And
12 that's where the inefficiencies that exist perhaps in the
13 systems, we're not dealing with the over-supply that exists.
14 MR. MCCARTHY: One real quick follow-up, Vince,
15 and that is that could be taken as competition. In other
16 words, when two hospitals buy PET scanners, it's because they
17 want to compete on some range of services.
18 MR. LERNER: Even when they're part of the same
19 alleged system.
20 MR. MCCARTHY: Well, I don't know the facts.
21 MR. LERNER: That's what he's talking about.
22 MR. MCCARTHY: Well, and the answer is yes. Even
23 within a system, two hospitals do continue to compete. I
24 mean, I don't know the particulars of that, but we tried the
25 whole system through a lot of aggressive certificate of need

1 where we pinched the supply pipeline in the hopes that that
2 would control prices, and it didn't do much good. I don't
3 think there's a study I've ever seen out of many, many
4 studies that finds that certificate of need works. When I
5 was at the Federal Trade Commission, I did a study on
6 certificate of need and I found all it did was keep out the
7 for-profit hospitals. If you treated the passage of a CON
8 law as indigenous, meaning that why did we pass one anyway,
9 the answer has a lot to do with the for-profits -- I'm sorry,
10 the not-for-profits in the state at the time trying to block
11 the entry of for-profits.
12 MS. GUERIN-CALVERT: I also think that the
13 presence of that kind of whether we call it over-capacity or
14 excess capacity relative to demand is something that, as Tom
15 mentioned, as you move toward a new equilibrium, is something
16 that players in the marketplace can make use of, because in a
17 circumstance where you have excess capacity and the desire to
18 fill it up, it makes the entity that has the excess capacity
19 either more vulnerable and more willing to cave in on various
20 terms and conditions or sets up more opportunities where
21 volumes can be diverted to an entity with excess capacity.
22 MR. ISELIN: But doesn't that assume that they're
23 not acting in tandem? If they were independent, that would
24 be true. But if they're all acting in tandem in one large
25 system, as you have on Long Island, how does that remain

1 true?

2 MS. GUERIN-CALVERT: I guess in part if what you

3 had was a circumstance where for whatever reasons you had all

4 of the hospitals in an area, in a marketplace, in a single

5 system, then you'd have Tom's, you know, monopolist that

6 you'd need to worry about. Where you have two or more

7 competing systems, where you have unilateral action, you have

8 games that can be played both within a system, across

9 systems, and also making use of other hospitals. If you have

10 something the size of Stonybrook, which is a full-service

11 tertiary facility located right in the center, you know,

12 that's a fourth independent player that one could look at.

13 You also have potentially the hospitals in Queens or even in

14 Manhattan for some services. But, again, you know, I think

15 in each case we have to put it in the market context as to

16 whether there are competing systems and whether there's

17 somehow concerns, which I haven't heard talked about, of

18 collusion among systems.

19 MR. LERNER: We'd need to debate this one case,

20 but I think that what the health plans in New York on Long

21 Island would say is that you cannot have a network without

22 both the two large systems. You have to have both of them.

23 Once you have both of them, you can't -- since each of them

24 know that you need both of them, you can't really play the

25 one off against the other. That's a factual premise; it may

1 or may not be true, but that's the perception.
2 MS. GUERIN-CALVERT: And I think that's why I'm
3 kind of going back to Tom's point, is it that that's the
4 problem that has been faced in every marketplace; is it that
5 if you can no longer drop somebody, if you have to must-have,
6 what tools do you have available to you? Long Island is one
7 of the few places where folks have actually testified that
8 they've been able to drop must-have hospitals. But, again,
9 that was a while back, it may no longer be prevalent. But I
10 think it is where you have to look at, even if you have to
11 have people in, are you able to negotiate good rates?
12 MS. LEE: I also had a question about tiering. I
13 mean, we've heard from on this afternoon's panel that this
14 has become a more common practice. It's no longer just in
15 network and out of network, but there are gradations of these
16 tiers. But we've also heard that there's a difference
17 between having a contract and usage. So, my question is, how
18 successful is tiering? That is, how successfully have health
19 plans managed to divert their enrollees to lower cost
20 hospitals and to follow up on that, how anticompetitive has
21 full-line forcing been?
22 So, you know, we've again heard that full-line
23 forcing has been a problem. Health plans are forced to take
24 these perhaps lower quality hospitals at these higher rates;
25 but if, in fact, enrollees don't go to those hospitals, you

1 know, my question is, what has the anticompetitive effect
2 been?
3 MR. LERNER: My only comment is I think that the
4 tiering thing in most of the marketplaces where I have
5 clients that are experiencing it, it's just too new. There's
6 very little experience with it so far. Some of that
7 experience has been an inability to get it off the ground.
8 And from that you can't really tell a whole lot about what
9 impact it has, other than the fact that the product didn't
10 get off the ground. In some other places where they are
11 being offered, it's just very early.
12 MR. ISELIN: Yes, I would add that the ability to
13 add tiering as a tool is very much going to reflect some very
14 important local characteristics to the health care
15 marketplace. And I think you were sort of making that point,
16 Brad, but from my perception, looking at sort of a range of
17 different markets, I think it's going to have limited success
18 as a tool. Again, I could explain why that's true in Buffalo
19 and why that's true for different reasons in New York City
20 and differently, again, in Albany, looking at the area I know
21 best, but, again, I think it's hard to draw across-the-board
22 conclusions about it, because that's a tool that very much is
23 going to reflect a lot of local conditions.
24 MR. STRUNK: Yeah, and I just wanted to echo what
25 Art said. I just a week ago returned from a week in Orange

1 County, California, which is one of the most advanced managed
2 care markets in the entire country. And it certainly is
3 probably one of the most advanced markets in terms of plans
4 pursuing these tiered network products.
5 And, you know, we spoke to health plans executives
6 and they just say, you know, that these really are brand new,
7 we're not -- we haven't seen huge savings from them yet, but
8 it is, you know, too early to tell. The plan that was the
9 leader in the market, Blue Shield of California, another
10 barrier that they faced, they ended up -- you know, they had
11 two tiers, a preferred and I guess a non-preferred, I'm not
12 sure exactly what they called them, but it ended up that just
13 a huge percentage of the hospitals ended up being in the
14 preferred tier anyway.
15 So, in the end, there wasn't all that much
16 steerage to do in the first place, because they all just
17 ended up in the preferred tier as well. So, I don't think
18 they're seeing, at least in what I've heard, I don't think
19 they're seeing the savings yet that you might expect to get
20 from this, but it's certainly new. And it will certainly
21 depend on the extent to which consumers really take up these
22 products.
23 MR. MCCARTHY: And I would add to that employers.
24 In other words, the tiering is new. In California, they
25 tried it. PacifiCare was trying to do it; Blue Shield, as

1 you mentioned. A long time ago, Blue Cross went to the whole
2 state and said to all the hospitals in the state, you can
3 either be on tier one or tier two, before it was really even
4 called tiering.
5 And just as Brad said, virtually everybody signed
6 up for tier one, but what that meant was that in order to get
7 that status was a discount. So, in effect, if you as an
8 insurer can get everybody to sign up for a discount, then
9 you've got both a broad system and a low price. And usually
10 that doesn't sustain because of -- you want that channeling
11 of the volume that you're giving the discount for.
12 It is very new. There's been some legitimate
13 concern by the hospitals about whether the tiering is
14 measured properly, and I really think that that's something
15 that should be hammered out in the negotiation.
16 They're worried, as I said earlier, about we're
17 high quality, how come we're put on the high tier. That
18 doesn't bother me so much as, you know, we do a high case
19 mix, so we have a different cost structure.
20 MR. COWIE: Tom McCarthy addressed the economic
21 theory covering a situation where the flagship hospital tries
22 to force payors to use the less desirable hospital. And I
23 understood your comments, there are a lot of hurdles to
24 developing really a strong economic theory to challenge that
25 kind of conduct. Does your analysis apply equally to a

1 situation where the flagship hospital tries to force payors
2 to use, say, the ambulatory services or the out-patient
3 services? In other words, the flagship hospital is trying to
4 restrict competition from an out-patient facility or a
5 boutique hospital, something in the same geographic area.
6 MR. MCCARTHY: Debra would be much more up on the
7 literature that would apply there, because I thought her
8 treatment of the literature was pretty comprehensive. My
9 basic answer is it applies the same way. What is raised by
10 the literature that Debra cites is whether these are --
11 whether in some ways some of the goods that are tied together
12 at the local level are somehow not independent and are
13 complements and you get maybe a different prediction.
14 But you still have to take some source of market
15 power and you have to leverage that somehow to another
16 service and create a barrier to entry to that service. So, I
17 think the basic analysis is the same. I'd consult Debra on
18 some of the details, but I think the basic argument is still
19 the same.
20 MS. HOLT: I would follow up that I think that
21 probably the -- at least based on existing literature, a case
22 would be probably easier to make with, say, a hospital
23 talking about other services in the same area that might be
24 used by the same patients, say, once while they're in and
25 once when they're out of the hospital.

1 MR. COWIE: Why is that?
2 MS. HOLT: Because you're talking about the same
3 consumer looking at the two products, say, rehabilitation
4 services the week that you're released and the
5 hospitalization itself as, you know, a bundle of services,
6 and that's exactly where, for instance, the Whinston sort of
7 model of time does apply. You know, you have a monopoly
8 power, say, in the hospital, but you have some competition
9 but imperfect competition in the provision of rehabilitation
10 services.
11 MR. LERNER: And I think one thing that I'd like
12 to explore that I think may be worth some further discussion
13 when we're on it, we don't have to do it today, it's the
14 question of why or whether the literature would support or
15 wouldn't support looking at the bundling at the level of the
16 health plan. We could view the health plan as being in a
17 sense an independent consumer, who's then reselling a rather
18 different product, being insurance.
19 I'm sort of curious about that, because your
20 discussion seemed to assume that that's not the case.
21 MS. HOLT: Okay, thank you for --
22 MR. LERNER: It maybe needs some further -- maybe
23 you've already thought this all through, you probably have,
24 but I think for me I'd have to -- I'd want to talk more about
25 that.

1 MS. HOLT: Well, thanks for asking that question.
2 I would like to just clarify that what I was trying -- the
3 point I was making is that the models that we sort of
4 reflexively look to when we hear this, you know,
5 superficially this set of facts don't fit nearly as well as
6 one would think initially.
7 I'm not saying that there isn't a model out there
8 that would show that these things are deeply anticompetitive
9 and harmful to consumers, just that we really need to think,
10 you know, more deeply about it and think about the ways in
11 which these practices and these exact institutions and
12 environments can lead to the anticompetitive outcome.
13 MR. ISELIN: Just to follow up again, maybe a bit
14 less theoretical, but possibly something to think through as
15 a good example would be the tying of in-patient and home
16 care. I mean, home care is, in my mind, a relatively
17 fungible type service. I mean, people don't generally say I
18 want this home care agency. I mean, they don't really care
19 who's giving it to them as long as they're getting some home
20 care. And yet, so if you took sort of a fact pattern, where
21 you had an in-patient facility and, for the sake of argument,
22 said it had market power, and they then said to the health
23 plan, in a situation where the consumer, ultimate consumer
24 really doesn't care much, well, we're going to -- you must
25 use our home care and the rates for that home care are three

1 times what you'd have to pay to somebody else, again, for a
2 service that's sort of relatively fungible and not consumer-
3 driven. I mean, you know, again, I don't know how all the
4 literature analyzes that, but I throw that out as a real
5 world example that may sort of outline the kind of question
6 you were asking and maybe just ask everyone, okay, how do you
7 work through that?
8 MR. LERNER: Have you got one, Harold? Have you
9 got one?
10 MR. ISELIN: Yeah, we do. I do, it so happens.
11 MS. GUERIN-CALVERT: Harold raises a good example,
12 because I think it shows the complexity of applying the
13 bundling literature is that one of the things that
14 differentiates health care is -- let's assume for the moment,
15 for whatever reasons, you have a situation in which the
16 hospital offers and the health plan accepts that they're
17 going to purchase not only in-patient but also home health
18 care, durable medical equipment, ambulatory surgery, a whole
19 variety of other services from the hospital.
20 It is the extraordinarily rare case that in a
21 particular marketplace those are going to be the only
22 providers of home health care, ambulatory surgery or out-
23 patient services available to the individual consumer. So,
24 even though it gets bundled at some level to the literature
25 that Debra spoke to, the individual consumer may indeed go

1 for in-patient orthopedic surgery to hospital X, but end up
2 in physical therapy with a completely independent physical
3 therapist with whom the health plan also has a contract, even
4 though they may have a contract with the physical therapist
5 at the hospital, or may end up for whatever reason with home
6 health care services from a third party.

7 So, again, it's the issue of even if allegedly in
8 the first round the contract price for the services for home
9 health care are set at three times the market level, it may
10 be that no patients end up purchasing the product from that
11 supplier. They may well go to others.

12 MR. ISELIN: Right, but you take it the next step
13 and part of the contract provision is you must use ours, that
14 the plan must --

15 MR. LERNER: Can't discriminate.

16 MR. ISELIN: Yeah.

17 MS. GUERIN-CALVERT: But that doesn't mean that
18 the patient has to use it.

19 MR. ISELIN: No, but --

20 MR. MCCARTHY: No, but does that mean it's an
21 exclusive, or does that mean that you have to contract with
22 us?

23 MR. ISELIN: It means they'll end up getting their
24 proportional share if no less.

25 MR. MCCARTHY: Well, it may mean even more than

1 that, unless you can steer, and I agree.
2 MR. ISELIN: What also happens, though, is --
3 MR. MCCARTHY: You can't as a no-steering
4 privilege.
5 MR. SCICCHITANO: Just the nature of that
6 situation, though, the hospital is very influential on a
7 member who just had orthopedic surgery and the hospital staff
8 is in there telling the patient -- or somebody's in there
9 telling the discharge planning is this is the best place to
10 go, and this is something that just happened yesterday. I
11 was notified that one of the hospital systems told every
12 health plan on Long Island, with the exception of Vytra,
13 maybe they knew I was coming here -- that they no longer are
14 allowed to have on-site nurses in the hospital. Now, I
15 haven't heard that because we were the ones excluded from
16 that, and I'm not sure what the reason is, why we were
17 excluded and why that happened, but they control a lot of the
18 discharge planning that influences that situation to get more
19 business in their direction at three times the cost.
20 MR. ISELIN: In other words, they effectively
21 block steering, and we can debate all the different ways that
22 that happens, but if you take the analysis with all the facts
23 and add in effective blocking through contract provisions or
24 utilization review or discharge planning or whatever,
25 effective blocking of any steering and almost total absence

1 of effective consumer choice, given that someone's in the
2 hospital being discharged and somebody's making home care
3 arrangements for them and the consumer isn't out there going,
4 "Well, I think I'm going to shop around for which home care
5 agency I'm going to get." You know, walk that all the way
6 through, and again, I'd sort of just be curious whether that
7 gets over the line for anybody or not.
8 MS. GUERIN-CALVERT: I guess part -- I mean, one
9 of the things is this has been -- the issues that you raised
10 have been a perennial issue, and one of the areas that I know
11 the FTC and other agencies, state agencies in particular,
12 have spent some time on is really trying to beef up
13 disclosure and conflict of interest regulations. And I know
14 that some plans have also tried to do that to provide as much
15 information to consumers as possible, that they do not need
16 to necessarily stay with the hospital system in order to have
17 quality of care. They can choose to do so, but to inform
18 them of their options, and in some cases, hospitals and the
19 discharge planners are required to let people know about
20 alternatives.
21 MR. LERNER: Just a final comment is a long, long
22 time ago, one of the things that made people think that there
23 was a breakdown in market forces in health care was that if
24 consumers were left to shop for health care, we would not get
25 a very market -- a very sound market result, for a variety of

1 reasons, including lack of information, and including the
2 fact that the time when the decisions were made is a time in
3 some cases when it's all fraught with emotion and other
4 distractions and the fact that the existence of insurance
5 means that for every, you know, dollar of health care that's
6 being spent, you know, only six cents or 10 cents or 12 cents
7 is coming out of the consumer's pocket.
8 So, for all of those reasons, there was a move
9 away, as Tom explained, from the indemnity, the classic
10 indemnity, health insurance model to a more managed care
11 model based on the premise, supported by antitrust thinking,
12 that the managed care plans, to some degree, become a proxy
13 for the consumer in the purchasing decision, or become a
14 level where they make the competitive choice in the
15 marketplace and avail themselves of the information and
16 competition and price competition, and then sell competing
17 health plan products to consumers.
18 If you structure the hospital services market or
19 the medical services market or any other market in such a way
20 that the health plans cannot really avail themselves of
21 competition effectively and then say, "Oh, but that's okay,
22 because we still have consumers who will still make
23 competitive choice." I think we're back in the problem that
24 we were at in the late '60s and early '70s.
25 I don't think you want a model where you don't

1 have competition between the hospitals and their dealings
2 with the health plans. There is certainly the case being
3 made for some reforms in health care that would go to, you
4 know, whole models of health care, where consumers go out and
5 buy their own health insurance on their own with a bucket of
6 money from their employer, without going through their
7 employer, where people have, you know, IRAs for health.
8 There's all sorts of other models that might completely
9 change the economic dynamic of how consumers function.
10 But right now, most people are still enrolled in
11 health plans where most of the dollars are being paid out by
12 the health plan and the consumer's exposure to cost
13 differences from one provider to another are relatively
14 modest, plus they have information gaps, plus they have
15 emotional issues that separate them from the decision.
16 So, I think it's still very important to focus on
17 whether or not there is vigorous and effective competition at
18 the provider level for participation in the health plans, and
19 not depend on the health plan's ability to tinker with co-
20 pays and tinker with referral mechanisms as a way to
21 reinstall competition after they've already had to include
22 everybody at prices that weren't competitive at the front
23 end. End of speech.
24 MR. MCCARTHY: Art, you're slipping into health
25 care policy, which is a bait I often take. But let me --

1 I'll try to keep it narrower than that. We came from a place
2 where there was a lot -- or basically everything was done by
3 co-insurance. And what ended up happening in the sort of
4 '60s into the '70s was that that co-insurance kept getting
5 lower and lower and lower, so that we had what we all called
6 first-dollar coverage or near first-dollar coverage. And
7 that's one place where the insurance really broke down.
8 Now, having said that, consumers have rejected, to
9 a large degree, the restrictive nature of gatekeeping and the
10 restrictive networks. Now, I think they're going to come
11 back to it. I'm fully agreeing with Brad as to where this
12 may go next. But, right now, what you have, the only way you
13 can deal with consumers in making decisions, if they truly
14 were to reject the whole managed care model, it hasn't gone
15 that far, but if they truly were to reject it is you're back
16 to co-payments. You're back to co-insurance.
17 And there was even -- I mean, one of Meg's
18 colleagues in the Dubuque case found evidence of co-insurance
19 differences causing people to go quite a distance. Rightly
20 or wrongly, co-insurance can move people around. But, you
21 know, it does matter how big that co-payment is.
22 MR. LERNER: All I'm saying is -- I agree. I
23 agree with you. I'm just saying I don't want to put all my
24 eggs in any basket.
25 MR. MCCARTHY: I would prefer to have them shop,

1 too, the insurers.
2 MS. GUERIN-CALVERT: I think one other basket that
3 I've seen some insurers develop very substantially is use of
4 the internet to do the information provisions to their
5 enrollees as to what their options are and also behind the
6 scenes to be encouraging physicians to be choosing particular
7 options. And, so, that's one of the things that has helped
8 people have a little bit better understanding of which
9 ambulatory surgical centers are in the plan that they could
10 choose from, just by going on the website.
11 MR. ISELIN: I guess that's prompting me to make a
12 comment, which Art has cautioned about the -- my level of
13 concern about publicly funded programs, Medicaid managed care
14 in particular, but, you know, it's nice to talk about the
15 internet, but now you go to Medicaid managed care and Child
16 Health Plus and networks like that, where the notion of full
17 disclosure and consumer shopping. I mean, you don't even
18 have co-payments or co-insurance.
19 And, you know, I'm not saying there isn't access
20 to the internet, but the notion of sophisticated consumer
21 shopping around and looking at quality data and everything
22 like that translated into Medicare managed care market where
23 you are still, as a health plan, expected and challenged to
24 negotiate aggressively for good prices to benefit the state
25 and the federal government and the ultimate payor there, you

1 know? I mean, there's kind of disconnect in my mind as to
2 how those theories really work when you get into some of
3 those different product markets.
4 MS. LEE: To shift gears a little bit, several of
5 my colleagues have talked about various economic theories of
6 tying and bundling, in terms of analyzing full-line forcing.
7 And I was wondering if we could just take a simpler approach.
8 I know that hospital merger cases have very much focused on
9 local and geographic markets, and in those matters, we've
10 been very much focused on patient demand in terms of defining
11 the geographic market. What is true, however, is that both
12 employers and health plans, while acting as agents for their
13 patients also have a need for greater geographic coverage.
14 I'm sure that Vinnie would say that he needs greater
15 geographic coverage in order to be marketable to larger
16 employers. So, when we think about full-line forcing and any
17 potential anti-competitive effects it may have, can we think
18 that maybe a network would have hold-up power when an
19 individual hospital would not and just look at it in a
20 simpler framework?
21 MS. HOLT: That was the framework I had in mind.
22 I believe that was the framework they had in mind, as well.
23 MR. MCCARTHY: That sounded like portfolio theory.
24 MS. LEE: A little bit, but it just seemed like
25 there was a lot of focus on tying and bundling, and while I

1 think that the analysis, certainly what you laid out at the
2 end, Tom, in terms of, you know, there has to be market power
3 somewhere and things like that, all of that would apply. I
4 mean, would this be a harder way to go than, you know,
5 looking at it as tying or bundling or --
6 MR. MCCARTHY: The problem I have with portfolio
7 theory, and most of us would say this sort of thing, the
8 problem is that if you're going to argue that what creates
9 the market power is the whole set of services or locations or
10 products, whatever it is, all bundled together, you sort of
11 have to say, why is somebody forced into consuming that whole
12 set as opposed to something less than that, and then that
13 requires some sort of initial market power to trigger it,
14 which means, I think we're right back to tying as the
15 underlying mechanism. And, so, you could have a portfolio
16 that does have market power, but it's not due to a portfolio
17 effect, it's due to having some market power in some market
18 to start with.
19 MR. LERNER: I agree with everything you said,
20 June, but then I lost track, so the only comment I would make
21 is if what you were saying is -- I had it in my prepared
22 remarks, but I didn't go through, is that --
23 MS. LEE: Right.
24 MR. LERNER: If you were, and to use our community
25 here, if you were to say to an employer, "I'm going to not

1 have" -- if you were going to tell me as a consumer, you're
2 going to have a hospitalization, do you need to go to a
3 hospital in Maryland?" Okay, I live in an area where if you
4 told me that if I got sick, short of going to the emergency
5 room, but for some sort of planned surgery, I couldn't go to
6 a hospital in Maryland, I'd say, all right, can I go to
7 Georgetown, or can I go to Washington Hospital Center, can I
8 go to Fairfax, and you said yes, I'd say, you know, I'm not
9 going to die over this, okay?
10 MS. LEE: Mm-hmm.
11 MR. LERNER: But if you, and I might be willing,
12 if my doctor said I want to take you to Virginia, or I want
13 you to go down to Washington Hospital Center from Maryland, I
14 would go, and my family has gone. But if you were to offer a
15 health plan in Virginia, this is my sense of what the reality
16 faced by the plans is, and whether it's portfolio effect or
17 what we sometimes call network effect, I don't know what you
18 call it, but if you'll go to a health plan and say all of the
19 hospitals in Northern Virginia have just merged, all of them,
20 not just most, not just the big Inova system, but they've all
21 merged, okay? By some of our traditional geographic
22 measures, you'd say, well, I don't really care because people
23 can cross the Potomac River and people can go to D.C. and
24 people can travel. But if you tried to sell, in a benefit
25 plan to an employer, a major employer in this community that

1 had no hospitals in Northern Virginia, you wouldn't sell it
2 to anyone. That's a fact. Now, I suppose at some price
3 difference, you could, okay? At what level, how big that
4 price difference would be, but it would be a lot -- but that
5 merged system in Northern Virginia that has every hospital, I
6 would bet, be able to raise their price more than 10 percent
7 before you'd see health plans starting to sell products with
8 no hospitals in Northern Virginia.
9 So, I think the whole geographic market issue in
10 those hospital merger cases, I don't know if that's the same
11 thing you're talking about or not, but I think there's
12 something.
13 MS. GUERIN-CALVERT: I think Art has teed it up
14 exactly right, and Tom may disagree, in the sense that if
15 what you have is a circumstance, just hypothetically, where
16 every single hospital in Virginia, in suburban Virginia is a
17 single network, at most what you have is the circumstance as
18 you laid it out, which is it would be difficult for health
19 plans probably to not include it in. It's a completely
20 separate issue as to whether or not that hospital system has
21 market power over in-patient hospital service prices.
22 Because, again, the key issue in how all hospital mergers
23 have been analyzed is if it is the case that a sufficient
24 number of patients who currently are going to the Northern
25 Virginia hospitals could be diverted separately to

1 Georgetown, Washington Hospital Center, GW, Sibley, Suburban,
2 Shady Grove, Johns Hopkins, fill in the blank, so as to make
3 a price increase unprofitable, then even though they're in
4 the network, the contract terms that they would have to offer
5 would be competitive ones. And that's the dynamics that you
6 need to analyze.
7 MR. LERNER: I agree with that question
8 completely, but the problem is when you look at statistics,
9 which would show you that 24 percent of all the people in
10 Northern Virginia come into the District to get their health
11 care, or whatever it would be. That's not a very good
12 statistic to measure what percentage of the patients who are
13 going to those hospitals now, could an HMO faced with a no-
14 steering clause actually get to leave?
15 MS. GUERIN-CALVERT: I think what you would have
16 to look at is how is it that the 24 percent are already
17 going, what happens in this area, very substantial number of
18 physicians in this area --
19 MR. LERNER: Sure.
20 MS. GUERIN-CALVERT: -- have privileges in D.C.,
21 Maryland and Virginia. There have been huge shifts from
22 people that were in D.C. moving out to Reston to have half
23 their practice there, have another -- so, again, it's very
24 fact-specific.
25 MR. MCCARTHY: I would agree with all of that. I

1 think, Art, I think you could construct a situation where
2 there is a relevant market, relevant geographic market that
3 is only Northern Virginia. It's entirely possible. I don't
4 know that the facts would really get you there. My
5 suspicion, like Meg's, is it probably wouldn't, but if you
6 could imagine, you know, geographic price discrimination to
7 minimize the flow, you could imagine finding that the people
8 coming into the District, others really wouldn't follow them,
9 for whatever reasons there were. It's entirely possible you
10 could find what you're saying.
11 MR. LERNER: The question I have is why wouldn't
12 they leave Virginia?
13 MR. MCCARTHY: Why would they?
14 MR. LERNER: Yeah.
15 MR. MCCARTHY: Because I think what would end up
16 happening; there are a couple of things that end up
17 happening. One of them is, and you're going to load on
18 provisions into the contract that will --
19 MR. LERNER: Well, you heard them all. You've
20 heard them all.
21 MR. MCCARTHY: No, no, no, no. But the answer
22 would be that what you would do is you would put in steering
23 mechanisms. You would do -- and if you couldn't -- well,
24 then, if you couldn't, you're going to get -- you're going to
25 have -- the insurer is going to have a much harder time

1 getting people from Virginia to come into the District, and
2 if they did, then there would be good reason to say that
3 historical patient-origin data doesn't tell you anything,
4 because that won't happen anymore. You have to get into the
5 mechanism of how people get there, and you can create a set
6 of facts that will make Northern Virginia a separate market.
7 I don't know if they're realistic, but you can create a set
8 of facts that would do that.
9 MR. COWIE: Before we finish, I want to ask a
10 question for the attorneys here, Art and Harold. If these
11 practices that have been described are occurring nationally,
12 one would expect to see some private litigation by, say,
13 rehabilitation service firms or boutique hospitals or EMS
14 firms on the theory that there's some kind of tying and
15 they're being foreclosed; I mean, is that occurring, and if
16 so, what are the courts saying?
17 MR. LERNER: On the specific question, the ones
18 where I've seen cases, is with ambulatory surgery centers and
19 such where a group of physicians on a hospital's medical
20 staff lets it be known that they're planning to build an
21 ambulatory surgery center or does build an ambulatory surgery
22 center and then the hospital in that community, and usually
23 there we're not talking about large multi-hospital systems,
24 it's often a single hospital in what may be a one-hospital
25 town, maybe, even adopting a strategy of response. And that

1 could be a very competitive response or an anti-competitive
2 response, and the border between the two is obviously
3 debatable.
4 But you see sometimes "alleged" "coercion" of
5 primary care physicians not to refer patients to the surgeons
6 who are at the ambulatory surgery center, alleged allegations
7 of pricing strategies with managed care plans to secure
8 exclusive status, which could be viewed as a competitive
9 response, or I suppose depending on the facts, anti-
10 competitive. But there have been at least two cases recently
11 of that that I'm familiar with, one of which in Louisiana the
12 plaintiff lost because they failed to adequately plead it,
13 adequately establish the geographic market. Their economists
14 apparently didn't cut the mustard. And then in the other
15 case, the court ruled let it go to trial. There are two of
16 those that I'm familiar with. I'm not familiar with much
17 more than that, though I'm sure there are.
18 MR. ISELIN: There's a third I'm familiar with in
19 New York, very similar to what Art described. It's actually
20 a fairly rural community, Rome, New York.
21 MR. LERNER: That was one of the two I was talking
22 about.
23 MR. ISELIN: Okay. And it's moving forward, it's
24 still in discovery, but that exact fact pattern where the
25 hospital, some physicians got approval to open up an

1 ambulatory surgery center. The allegation is that the
2 hospital said to the plans, we will give you favorable in-
3 patient rates if you refuse to contract with the ambulatory
4 surgery center.
5 MR. LERNER: And I should mention a Pennsylvania
6 one, not familiar with litigation -- there are a number of
7 hospitals I'm familiar with in Pennsylvania that have adopted
8 a strategy that says before you can get hospital privileges,
9 we will screen your application, and on your application we
10 will determine if you have a "conflict of interest." And a
11 conflict of interest would include, apparently, an ownership
12 interest in something that competes with the hospital. And
13 they also say, if it turns out that at some future point in
14 time your answers to any of these questions would be
15 different, your privileges are thereby void. So, there are a
16 number of -- I'm not familiar with litigation around it, but
17 that is a practice I know a number of hospitals are using.
18 In fact, it's included in the hospital advice manual that a
19 popular law firm gives out to hospitals to tell them how to
20 cope with these outbreaks by doctors.
21 MR. COWIE: Thank you very much for your patience.
22 I believe the hearings resume tomorrow at 9:15.
23 MS. MATHIAS: Actually, I did want to affirm that
24 they do start at 9:15 tomorrow morning. We will be
25 discussing issues in litigating hospital mergers. We hope

1 that everybody can attend.
2 We also wanted to note that, as is evident, we
3 unfortunately did not have a hospital on the panel today, and
4 we think that would have added to this discussion. However,
5 we do hope that hospitals and other entities will feel free
6 to send in written comments. The method for doing that is
7 described within our every press releases. And you can -- if
8 you haven't seen one of our press releases, they can be found
9 at www.ftc.gov.
10 Tomorrow is only a morning session. We will start
11 at 9:15. I believe we end at 12:15. And I wanted to also
12 note that on that website we have the April through May
13 agendas so that you can continue to see where we plan on
14 going in the future.
15 And one final note, I wanted to thank all of the
16 panelists for giving us their time, effort. This is not an
17 easy task to ask them to come up, and we really do appreciate
18 the thought and time that you've put into this. And a round
19 of applause to everyone.
20 (Applause).
21 (Whereupon, the hearing was concluded.)
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12 **C E R T I F I C A T I O N   O F   R E P O R T E R**
13
14 MATTER NUMBER: P022106
15 CASE TITLE: HEALTH CARE AND COMPETITION LAW
16 DATE: MARCH 27, 2003
17
18 I HEREBY CERTIFY that the transcript contained herein
19 is a full and accurate transcript of the notes taken by me at
20 the hearing on the above cause before the FEDERAL TRADE
21 COMMISSION to the best of my knowledge and belief.
22
23 DATED: APRIL 4, 2003
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25 ______________________________

1 RITA HEMPHILL

2

3 **C E R T I F I C A T I O N   O F   P R O O F R E A D E R**

4

5 I HEREBY CERTIFY that I proofread the transcript for

6 accuracy in spelling, hyphenation, punctuation and format.

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8 ___________________________________

9 SARA J. VANCE