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PRESENT:

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HEALTH CARE AND

COMPETITION LAW AND POLICY

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FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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MS. MATHIAS: Good morning. Welcome to the Federal Trade Commission Department of Justice hearings on competition law and policy in health care. We're very glad you could join us this morning, and for the people listening in, we're pleased you could be here as well.

We are going to start this morning with remarks from Commissioner Sheila Anthony. Just a quick introduction of the commissioner, who is actually another Arkansas person. We actually have a plethora of people from Arkansas, so it's lucky for me, because I get to hear a lot of accents that sound very familiar.

Anyway, Commissioner Anthony has been a member of the FTC since 1997, and is the longest-serving commissioner on the current commission. Commissioner Anthony also served as Assistant Attorney General at the Department of Justice. Most importantly, as I've already said, she is from Arkansas, so she is particularly suited to introduce today's panel. And with no further ado, Commissioner Anthony.

COMMISSIONER ANTHONY: Good morning, everyone. Is this microphone on? I can't tell from here.

Thank you, Sarah, for the introduction, and welcome panelists. We want you to know how much we appreciate your graciously changing your schedules to accommodate today's session, since it was cancelled in February due to the ice storm.

I'm delighted to join you this morning. Although I haven't lived in Arkansas for many years, my husband and I have long and strong ties back there, and many of our family members still live there. And so, Arkansas health care is more than just a professional interest to me, as you might expect.

I'm pleased that the organizers of today's hearing have singled out Little Rock for an in-depth study. Having said that, however, I want to emphasize the broader goals of today's session in conjunction with a session on Boston, an earlier panel that focused on that health care market.

It's impossible to analyze competition issues in a factual vacuum, because antitrust is so fact-specific. This is especially true in a health care market, where regional differences can dramatically affect the dynamics of competition. For example, back in February, the panelists discussed the very high level of HMO penetration in the Boston area, as well as the prevalence of large multiple hospital

systems.

In contrast, the HMO model has not made much of an in-road into Arkansas, but one insurer has a particularly large market share. I expect that today's panelists will tell a different story about relationships between payors and providers than did the earlier session on Boston.

The Federal Trade Commission and the Department of Justice have two responsibilities, primarily they are law enforcement agencies, but they also have a unique role to play in shaping antitrust policy. We need to ensure that the policies that we advocate are specific enough to be useful to you, but broad enough to cover a variety of factual situations.

When these hearings are concluded, and we reflect on what we've learned, I'm sure that today's session, along with the Boston session, will go a long way in grounding our discussion in real world facts.

Finally, I would like to raise one other issue. It may not be directly relevant in today's session as originally conceived, but it's been long near and dear to my heart, and I would welcome the thoughts that the panelists may share with us this morning. I've encouraged others at the Commission to be particularly sensitive to the differences between urban and rural

health care.

When it comes to obtaining health care services, residents of rural areas tend to face different and sometimes discouraging choices along the cost/quality/access continuum. To the extent that health care facilities in Little Rock, including, perhaps, specialty hospitals, draw patients from rural areas, I wonder how this impacts competitive dynamics in our state, and in Little Rock, particularly.

I also wonder what it says about the quality and availability of health care in rural areas and what role competition really plays there. I look forward to today's discussion. I thank you for your time. We appreciate your being here, and I'll turn the microphone back over to Sarah, and sit in the audience and learn from you. Thank you very much.

(Applause.)

MS. MATHIAS: Thank you, Commissioner Anthony.

Just a couple of ground rules, as we begin today's session. As Commissioner Anthony said, we are very grateful to all of you that you could spend the time to not only travel here, but to prepare, to just spend time thinking about what we're going to be talking about so that you can teach us so that we can learn and listen.

The air system sometimes comes on a bit strong, so if everybody could make an effort to talk into the microphones, that would be very helpful for the people in the back of the audience, as well as for the people on the speaker phone, and most importantly, the court reporter. We are scheduled today, as Commissioner Anthony stated, to look at the Little Rock market. We will go until 12:15.

Just so you know the rules of the game today, I will give short introductions for everyone on the panel, but we do want to spend more time with the discussion than spending time going over everyone's outstanding credentials. So, we have a bio book hand-out in the hallway so that everybody can get the full depth of the talent that we have on our panel today.

Also, as we begin, everyone will have -- all the panelists will have approximately ten minutes to speak, and we will begin in order, but first my introductions. We will start today with Kevin Ryan, who is at my far right. He is the Project Director for the Arkansas Center for Health Improvement, and Assistant Professor at the University of Arkansas for Medical Sciences College of Public Health.

To Kevin's left is Joe Meyer. Joe is Director

of Corporate Benefits Planning for ALLTEL Corporation, and he has more than 30 years of experience in the area of strategic planning within the human resources field.

Dr. John Bates is to Kevin's left, he is the President and CEO of Arkansas Children's Hospital in Little Rock and he has been there since 1993. In some ways, I hold Children's Hospital particularly dear to my heart because I actually volunteered there for a bit of time when I was younger. Before joining Arkansas Children's Hospital, he was a Senior Vice President at the Children's Hospital and Health Center in San Diego, and an administrator at Memorial Miller Children's Hospital, Long Beach, California.

Immediately to my right is Russ Harrington, President and CEO of Baptist Health. Baptist Health is composed of five hospitals, a retirement community, a residential care facility, and a medical service organization, and Russ has been with Baptist since 1984.

I actually failed to introduce my co-moderator, Ed Eliasberg. He is with the Department of Justice.

To Ed's left is Dr. Jim Kane, he is a cardiologist and a senior member of the Little Rock Cardiology Clinic and practices at the Arkansas Heart Hospital.

To Jim's left is Bob Shoptaw. He is the Chief Executive Officer for the Arkansas BlueCross and BlueShield and has been with Arkansas BlueCross and BlueShield since 1970.

Finally, last but not least, is Dr. John Wilson, he is an orthopedic surgeon and practices at Ortho Arkansas, which is a 20 physician orthopedic clinic and ambulatory surgery facility in Little Rock, Arkansas. He is also an accomplished pilot and he may have actually flown here today, for all I know.

As I said, the agenda today is quite simple. We wanted to listen, learn and ask a lot of questions. The questions will be asked by Ed and myself as the moderators, and as we proceed, some of the questions will be directed to a specific person, or they may be directed to the panel as a whole. One of the ways that helps us keep the question and answering going smoothly is if there is a question that's out that people want to address, if you just turn your tent sideways, it allows us to know who wants to speak and usually we can keep track of the order that way and it's very helpful for us. I think often the comments or answers elicit more comments, and so we definitely want to stir the discussion here.

Without any further ado, if Kevin would start

for us.

MR. RYAN: Thank you all very much for having me here today. As Sarah said, my name is Kevin Ryan, I'm a health law attorney, faculty member in the UAMS College of Public Health, Department of Health Policy and Management, and probably most specifically and applicable to our talk today, the Project Director of the Arkansas Health Insurance Roundtable.

Arkansas Health Insurance Roundtable was formed about three years ago, with funding from Herza and subsequently the Robert Wood Johnson Foundation's State Coverage Initiatives Program to look at the issues of health insurance status of Arkansans. Clearly, that has application in our discussion today on competition in health care provider marketplace and the health care provider carrier interaction.

Not surprisingly, in Arkansas, and in Little Rock, as in the rest of the nation, the big issues that face our state surround the issues of access to care, quality of care, and cost of care. Now, Arkansas, unlike a number of states, is a very unhealthy state. We have very high rates of illnesses in our state.

Clearly, research has shown that these are related to the high rate of tobacco usage in Arkansas. We have a very, very high rate of obesity. We're the

second in recent statistics; we were the second most obese state, if you will. And in that cohort, just to the other side of Mississippi, both geographically, and in number, and we're about to close in on Mississippi as well.

We have too much physical inactivity. We don't exercise enough in Arkansas. We don't use seat belts enough. And Arkansas, as with most rural states, we have a very high rate of usage of automobiles. We have long distances to drive. In combination with lack of seat belt usage, that clearly leads to increased rates of trauma. We don't wear helmets. Arkansas had a motorcycle helmet law that it recently in the past few years overturned. And so we don't wear helmets for motorcycles, nor for bicycles.

The Arkansas Health Insurance Roundtable was formed with this funding to study this issue of health insurance status of Arkansans to find out what health insurance status meant in Arkansas, and importantly, what it meant not to have health insurance. Who were these people; if they had health insurance, where did they get it? If they didn't have it, what did they do in response?

A geographically diverse body, not the usual players, if you will, and this is a group of folks who

are involved daily in decisions surrounding health insurance, either as consumers, as employers, purchasing health insurance coverage for their employees, or as carriers or provider representatives.

Their goals were a couple-fold, but it mostly centered around finding out what health insurance status is in our state, developing this long-term strategic plan to address these issues -- health insurance status currently came about over the last several decades, and so it was clear to this group that solutions to address the problem wouldn't come about in a very short period of time, you needed a longer-term strategic plan.

Two major goals: Increase the number of Arkansans covered by health insurance, while promoting marketplace stabilization. The worst thing they felt they could do would be to create and craft perhaps some very well intentioned solutions and answers that would ultimately lead to destabilization of the marketplace.

Without reading this whole slide, suffice it to say that this has been an effort that we have seen involvement in state-wide.

Now, I have 10 minutes or so to talk, but I could tell you everything about the Arkansas health insurance marketplace in this one slide. This is

everything you need to know. If you see nothing else, if you read nothing else, remember nothing else from my presentation, take this away and you have it, in one fell swoop.

In Arkansas, most health insurance, as with the rest of the nation, is received through employers. Seventy-five to 80 percent of those with health insurance receive it through their place of employment.

For those above 65, they receive coverage through Medicare, a system that's being worked on, as we've seen with the discussion over the past few years with prescription drug benefits, but it does provide coverage.

In Arkansas, for children below 200 percent of the poverty level, we have the very well developed and very well implemented our kids first program, providing coverage for those kids. But for adults, ages 19 to 64, in Arkansas, unless you're categorically disabled for longer than six months, and have a household income less than 25 percent of the federal poverty level, and have household assets less than $2,000, you do not qualify for any type of government health insurance -- state operated health insurance coverage.

So, clearly, there's a safety net issue involved here. These people will receive care, but

without a mechanism to attain reimbursement for that care, there's a real -- and a dramatic -- impact on our health insurance health care provider system in the state.

And that's what the roundtable sought to address, conducted a survey, the first state-based survey of health insurance status in Arkansas. Made a number of findings. Not surprisingly, as with the rest of the country, the majority of Arkansans who are insured, receive it through their place of employment. This is a key and important fact which guided the roundtable in crafting their recommendations to address the health insurance marketplace in the state.

If you're a large employer, or an employee of a large employer in Arkansas, the chances are very good that you will have health insurance coverage available. Arkansas leads the country in its percentage of large employers, those with greater than a thousand employees, who offer health insurance coverage. But if you work for a small employer, then your chances are not as good. Over two-thirds of the small businesses in the state are able to offer health insurance coverage. Not surprisingly, the majority of the businesses in Arkansas are small, and so this leads to a very clear problem of access for people who don't

have health insurance coverage available to them at all.

And for those seasonal contract workers and part-time workers, again, there's no reasonable cost effective mechanism available to them.

Findings regarding uninsured Arkansans. In a state of only 2.65 million people, over 400,000 Arkansans don't have health insurance. So, that's almost 16 percent of the total population. Now, that's of all ages.

Let's go back to that page group of 19 to 64 again, those prime working years. In that age group, 20 percent, one in five Arkansans, have no health insurance coverage. It's even more dramatic if you're in the 19 to 44-year-old age group, one quarter have no health insurance coverage available.

Echoing Commissioner Anthony's statements earlier, most of these uninsured live in our rural areas, not the urban areas of Arkansas. While there's clearly a problem of lack of health insurance in the urban areas, it's more dramatic in the rural communities and smaller communities in the State.

Most uninsured work full-time. This is a fact that I didn't appreciate until we gathered these statistics in Arkansas. This is not an issue for

people who are not working. Clearly, it is an issue for them, but it is not the non-working who make up the majority of the uninsured. The uninsured are working, and they're usually working full-time, but again, they have no mechanism available to them to purchase health insurance coverage.

We surveyed our employers in the state, in both Little Rock and state-wide. Most of our very large employers are self-insured. They choose to bear that risk themselves as a mechanism to more tightly control costs and because they are able to do that, they are able to assume that risk.

Premium increases are very dramatic for all employers across the state. Clearly double digits, 20 to 35 percent or more annually, is not uncommon.

Arkansas families also face challenges to obtaining health insurance coverage. As we said, we're an unhealthy state, and that very much drives the cost of health care. We have increased prescription drug utilization, this drives health care costs.

Uncompensated care, that care that's received by those Arkansans without health insurance coverage clearly permeates and affects the entire system.

In talking with our Arkansas families and household members, they told us over and over that they

want health insurance coverage. They realize, and clearly acknowledge, that this is something that they need. They understand it's important, but because of the pressing need of daily financial concerns, this is something they're able to defer.

And finally, debt related to the provision of medical care. Arkansas, like a number of states, but especially in the southern region, debt related to medical care is oftentimes the leading driver of personal bankruptcy filings, obviously affecting the person and family. But the entire community as well is affected by these bankruptcy filings.

An important slide, the majority of the uninsured in a pure number standpoint are obviously not the wealthiest, the above 200 and 400 percent of the federal poverty level, but also it's not the very poorest in the state. If you look at that middle, the second set of bars, in the hundred to 200 percent federal poverty level range, that's where the majority of the uninsured are in the state. So, again, it was these types of facts that the roundtable used in creating their series of recommendations.

This is some new research that's just been developed over the past two months. I would like to just point you to a few of these blocks for a second.

This is the impact that the uninsured have had on Arkansas hospitals over the past few years. Now, a couple of caveats to remember here, this is just inpatient care.

So, when you factor in outpatient care for prescription drugs, other services, et cetera, the effect becomes more dramatic.

In 1999, there were not quite 18,000 patient admissions, inpatient admissions, who didn't have health insurance coverage, representing a little over $150 million of uncompensated care.

Now, remember, this care has to be absorbed by the system. It's absorbed, of course, by the health care providers initially, but ultimately the entire system pays for this care. Well, it's only gone up. By the year 2001, the last year for which figures are available, almost a quarter billion dollars in inpatient care alone was uncompensated, uncovered for patients received in Arkansas hospitals. It has a dramatic effect on our system.

This lack of health insurance in a state directly contributes to a number of factors for Arkansans. It causes poor health. Those Arkansans and those Americans without health insurance coverage tend to delay the care that they receive, and it's

understandable. If you have rent and if you have other daily pressing financial concerns, health insurance coverage and health care is something that can sometimes be delayed, but it's only delayed until the care can no longer be delayed, and instead of being received in a more timely, more cost efficient manner on an outpatient basis where preventive care could oftentimes take care of the problem, it's then received in an emergency department, where the care is both more costly, and ultimately oftentimes less efficient.

And so that increase of care, then, is not able to be paid for, oftentimes the patient has no -- and the family has no health insurance coverage, so again, that spreads throughout the entire system. Definitely leads to an increased cost of doing business.

Now, the roundtable made a series of recommendations based on the findings that they received from the survey of Arkansas households, from conversations with Arkansas health insurance carriers, conversations with Arkansas employers. I won't go over each and every one of these because of our time constraints; however, the roundtable's entire report is available and the URL is listed on the website. Also, my contact information is, so if you have any trouble downloading that, don't hesitate to give me a call and

I would be happy to make a copy of that available to all of you.

So, we will go through these slides pretty briefly, and then I'll point to some successes that we've had, and some progress that we're making in this regard.

The roundtable did support increased expansion of the safety net using tobacco settlement funds. In our state, Arkansas is one of the few states that chose to use their entire tobacco settlement proceeds directed towards health care. And so part of this is being used for expansion and creation of a safety net program. Remember on that first slide that I showed you, we discussed that there was no true safety net. Well, this will establish one for very low-income, adult Arkansans.

We've expanded coverage, income qualification levels for pregnant women. Now, one of the pending key successes, I think, will be the establishment of the Arkansas Safety Net Benefits Program. Again, keeping the round table's findings in mind, this will establish a program, establish essentially an employer state family partnership to allow employers to, in essence, buy into the state's Medicaid program.

Waiver has been submitted, waiver application

has been submitted to CMS, we're awaiting reply on that even as we speak.

We have sought to establish community-based purchasing pools. In Arkansas, like a lot of states, this has not been successful. While a very good idea, I think, in concept, and a well intentioned idea, purchasing pools historically have tended not to work very well and I think that's been the case in Arkansas as well.

There are some things that our round tables like to call no-brainers, including scientifically supported preventive services, and health care plans, and this is very important -- including those services that the research shows, that evidence shows, do contribute to and make health care more cost effective, and promoting education between employers and employees.

One of the findings that we've made over and over is that oftentimes an employee in a facility with health insurance coverage will leave that facility for a job, say, making an extra dollar an hour. That's a significant salary increase. But if that new employment is without health insurance coverage, the first time that employee has a traumatic event, has to access health care, then they've lost all benefit of

that salary increase. So, we've encouraged employers to engage in education and campaigns with their employees, to show them the benefits, the true salary dollar benefits of health insurance coverage.

And again, some other mechanisms and recommendations that have been made to attain those two twin goals that we talked about at the very beginning, expanding health insurance access while promoting marketplace stability. These are flushed out in more detail in the report, if you have questions about that, or we can discuss later.

And so this is what health insurance coverage could look like in our state. If you think about that earlier graph, for those folks with health insurance coverage in that angled block there at the top, if they lose that coverage or never have it in the first place, instead of falling all the way to the bottom, putting some of these programs into place could create both those safety nets and other alternative mechanisms to make health insurance coverage available.

Now, it's been sometimes sort of depressing, this whole process, talking with Arkansas employers and families, talking with carriers faced with daily issues of trying to contain costs and providers trying to contain costs. Discussing the poor health that the

state is faced with, our budget crisis. And we've had some successes as well, and some reasons to be positive.

As I said, we've applied to CMS for a Medicaid waiver application to establish the safety net benefits program. That's moving forward nicely. Our legislature has passed the authorizing legislation to put that program into place upon approval by CMS. We've established a health data initiative in the state, pooling health information coming from disparate state agencies that collect that, so that efforts like the round table and other efforts can be supported by real information, so that our policymakers in the legislature and in the executive branch can have information to base policy decisions on so that those decisions can be more effective and really mean something.

We're establishing a joint interim committee on health insurance and prescription drugs to provide a long-term platform to continue to study these issues in this state.

We're continuing to develop the structure of this safety net program so that upon approval, we'll be able to put this into place in very short order, and continuing and planning for enrollment efforts to make

this program a success.

So, there is a lot of reason to be encouraged. We have a lot of people working on these issues. It's gained a lot of attention within the state.

I am open for your questions, at the proper time, and I thank you all very much for having me here today.

(Applause.)

MS. MATHIAS: Thank you, Kevin.

Next up, Joe Meyer.

MR. MEYER: Good morning. You'll have to bear with me, this is the first time that I have spoken using Power Point, so I may be a little awkward, but we'll work through it.

As Sarah said, my name is Joe Meyer, and I am Director of Corporate Benefits for ALLTEL Corporation. ALLTEL is a Fortune 500 telecommunications company with over 20,000 employees in 26 states. Little Rock is home to not only both the company, but over 3,000 of our employees.

ALLTEL offers its employees a choice of health care plans to choose from and provides an equal dollar subsidy towards the cost of each health care plan. ALLTEL then contracts with a sufficient number of HMOs to allow employees the opportunity to access a wide

range of providers by participating in managed care networks. Employees then choose the health care plan that best fits their needs and the plans compete for membership. This results in employees paying more to participate in higher cost plans.

As the slide shows, the company monthly subsidy for single coverage is $220 a month, irrespective of the health care plan the employee chooses. So, employees, in selecting a plan, have the opportunity to not only look at benefit differentials, but also cost differentials. And the same is true with family coverage. The monthly subsidy provided by the company is not determined by the cost of any one plan option or directly tied to the rate of health care inflation. Rather, it is set based upon the company's ability to increase revenue in order to offset the expenses or as an offset to wage increases.

Based on the circumstances in any given year, we may forego increasing the subsidy, increase it by the same percentage as the salary budget, or at some greater amount up to the level of health care inflation. We find this is preferable rather than an open commitment to employees to subsidize X percentage of the premium each year, as most companies' revenues are not growing at the same pace as health care

expenses.

During the last several years, there has been considerable change in the health insurance marketplace. In the mid to late nineties, we offered five different HMO type products as well as an indemnity plan to our employees in Little Rock. This competition resulted in minimal increases to our health insurance premium costs for the first few years. However, beginning in 1999, as the managed care industry consolidated, we lost both Health Source and Prudential, both successor companies, Aetna and Cigna, withdrew their HMO products from Little Rock.

The cost of health insurance has continued to increase dramatically since 1999. In Little Rock, our health care premiums have risen an average of 16 percent per year since 1999. While the actual premium levels are slightly lower than the average of our other markets, the rate of increase in premiums over the last four years has been greater than the 13 percent annual rate experienced elsewhere.

While we continue to offer three HMO options, along with a new PPO option, in order to maintain the affordability of health insurance for all employees, we have increased copayments for office visits and emergency visits, as well as introduced hospital

deductibles. We have also carved out the pharmacy benefit and introduced a three-tier formulary.

These actions require the uses of health care services to pay more of the cost than they were required to in the past.

In making the decision as to what health care plan to enroll in, employees consider the cost to them in premium and copayments, as well as the hospital and physicians who are in each network. Since most physicians and many specialists participate in more than one network and the plan designs are similar, most employees consider premium costs and hospital affiliation.

In Little Rock, if you would like to access the Baptist Hospital, you need to enroll in the BlueCross PPO or HMO. UMAS and St. Vincent's are affiliated with United Health Care and HMOs. Arkansas Children's Hospital is a participating provider in each of these plans. The fifth, Arkansas Heart Hospital is not in any of our networks and only accessible through the PPO as an out-of-network provider.

Given our defined contribution strategy, our employees are well aware of the accelerating cost of health care. Their response has been to move to lower cost plans, even if it means more hassles to access

specialists, and also to drop dependent spouses who may have access to coverage through their own employer.

And this gives you an example of a large employer in Little Rock and how we deliver health care insurance to our employees.

Thank you.

(Applause.)

MS. MATHIAS: Thank you, Joe.

John Bates?

MR. BATES: Good morning. I don't have slides, I'll just speak.

I would like to talk a little bit about the Children's Hospital and about how we are configured and how we function as a specialty hospital and a little bit about how competition relates to us, and I would like to save discussions about cost and quality drivers for the question and answer period.

The Children's Hospital is unique in the state of Arkansas. We are the only facility dedicated to the acute care of children, and we have really no other important focus of pediatric care anywhere else other than the neonatal intensive care units that are in the large hospitals with large obstetric services. Even though we're unique and atypical in our own state, we're very much like about 50 other such children's

hospitals around the country who share many of the same characteristics that we have. And I would like to kind of explain a little bit as we go along about the difference between our facility and some of the newer boutique facilities, if you like, that have come on the scene recently.

So, to that end, let me tell you a bit about our hospital and a little bit about how competition affects us. Our hospital is an independent 501(C)(3) not for profit organization that was founded in 1912 as a home finding society for orphan children. And as these children were difficult to place in homes because of their medical status, we got in the business of trying to improve their health, and one thing led to another and pretty soon we had a lot of sick children and no orphans and became an acute care hospital and now we're a rather large outpatient clinic program.

Today we function as the state-wide safety net provider for all children, regardless of their financial circumstances. So, as you saw in Kevin's slide, that whole left end of the chart, if it's a kid who lives in Arkansas and he needs our services, he gets them, no questions asked, and we'll sort out the money as best we can after the fact. Just as an article of faith with our board, and it will be the

last thing that goes down in our hospital.

Medicaid is our largest payor, accounts for about 55 percent of the revenues that come into the hospital, and in turn, the Children's Hospital is the largest single hospital recipient of funds from Medicaid. So, no other hospital is as large in Medicaid ties.

We provide every aspect of care for children, other than liver and lung transplantation, and basically because there's not enough business in our state to support those programs. We are the only Children's Hospital in America that is certified as a Medicare, not Medicaid, but Medicare heart transplant program, and we are very proud to be one of three such centers endorsed by the national BlueCross BlueShield organization.

We have 281 beds and typically have more than 200 of them occupied on any given day. Normally, 40 to 50 of those 200 children are on respirators. That will give you some idea of the level of acuity and sickness of this population, which is quite remarkable and atypical even amongst the children's hospitals.

We have about a quarter of a million outpatient visits a year, and our annual budget is about a quarter of a billion. We operate a system of transportation

for both ground and air support for all the rural areas in our state, and we move about 2,000 sick children a year through those mechanisms to and from every county in our state.

We are a teaching hospital. We are a member of the Council of Teaching Hospitals and a primary affiliate of the University of Arkansas for Medical Sciences, UMAS, you heard about earlier.

Basically all the physicians who are faculty caring for children, or who are in training about children's conditions, do so on our campus. About 600 employees of the university, faculty, supporting staff and so on, are based at ACH. Each year we have research grant support of about $15 million and we publish dozens of scientific papers every year in medical journals.

We enjoy an excellent reputation for care in our community, and we've got wide-based support in terms of volunteers, thank you, Sarah, donors, and from the government and legislative branch as well. We will be providing to the Commission copies of the tape, the ABC special that was broadcast in August nationally that talked about our cardiac intensive care unit, a four-hour show we think illustrates both the highly technical nature of our institution and the highly

human quality of care that we provide.

In short, our hospital is a tertiary teaching Children's Hospital and we think by most criteria ranks among the leading hospitals in the country who care for children.

Now, in terms of competition, we experience it on multiple levels, and the most straightforward one, if you will, is on a business or financial level. We experience competition particularly with local hospitals for older children with simpler conditions, so that a 15-year-old with a simple fracture or who needs a hernia repair might well receive such care in a community hospital or other hospital in Little Rock, and if we wish to compete for that business, we have to get down on the price and get competitive with what those folks are providing.

On the other hand, for care like heart surgery or leukemia or for trauma care, we basically don't have competitors in Arkansas, but we have competitors regionally and nationally for those services that tend to set the market in that regard. So that we are attentive on those issues, and a good example of our competition there is St. Jude's Hospital, which is a children's cancer research hospital in Memphis, 125 miles away from us, and right up on the Arkansas

border, and they compete with us rather strongly for children with cancer.

So, we understand the challenge to us in terms of the business side of the equation. We structure our market so we can be competitive locally on the lower end of the spectrum of care, and competitive regionally or nationally at the higher end for more complex care.

We have contracts with all but one of the major payors in our area and I was pleased to see your comment on your slide that we are in all three of the plans or four of the plans that you provide. We try to do this by not aligning exclusively or preferentially with one payor or another as we go along. We call this plan the Switzerland strategy. We wish to be neutral in all of this, and it's important to us partly for business reasons but partly because it helps us maintain a critical mass of employees and experts in the disciplines that we need to take care of children. If we only had a third of the market, we could not provide the services that we provide. It just wouldn't be sufficient.

We also understand competition in other ways as well. We compete for staff. And this is probably a more serious challenge. Nurses, respiratory therapists, pharmacists, all the other licensed

professionals that we all need in our hospitals are in short supply. And so, when a new hospital or specialty hospital comes to town and opens their doors, they will attempt to recruit staff from the community and either directly or indirectly that affects the patients -- that affects the staffing of our hospital and we have to take steps to respond to that.

We compete for physicians. In a pediatric hospital, we need pediatric sub-specialists, and in our country, there were, for example, in 2001, less than 10 physicians graduated from training programs to be credentialed as pediatric phrenologists, experts in kidney disease, and there were over 200 jobs available around the country. So, the 200 jobs chased the 10 applicants, and not everybody won out, of course.

We're still short of specialists in areas like infectious disease, gastroenterology, diabetes, neurology, et cetera. And so we compete nationally and even in some cases internationally for physicians in these specialty areas to round out our complement of services.

We also compete for the philanthropic dollar, and we just don't compete with other hospitals, we compete with things like the symphony, churches, football teams, you name it. Everyone is out there

trying to find that support.

We compete for volunteers, and I'm pleased to say that we are very effective in that regard, but it is one of those challenges for us in terms of competition.

I hope this gives you a little background about our hospital. I think you will see that we are rather different in some ways than the for-profit specialty hospitals. We have a long and deep tradition, and I hope this background will be helpful when we get to the discussion.

Thank you.

MS. MATHIAS: Thank you, John.

Russ?

MR. HARRINGTON: Good morning.

For more than 80 years now, Baptist Health, a 501(C)(3) nonprofit organization, has been delivering, throughout our state, quality health care. As one of Arkansas's leading health care organizations, Baptist Health consists of five hospitals, with 1198 licensed beds, including 120 rehabilitation beds, a 400-resident retirement center with a skilled nursing facility, a physician service organization and an HMO joint venture, a 10-hospital VHA affiliate network, schools for nursing and allied health, and many other

health-related services. It's governed by an independent board of community leaders.

Baptist Health focuses each day on the values of service, honesty, respect, stewardship and performance, while it delivers comprehensive, compassionate health services to the people of Arkansas. The physicians, the nurses and employee was Baptist Health advocate wellness and prevention, along with treatment of illness and injury.

Three of Baptist Health's medical facilities are located in the center of the state in Little Rock. In the remaining areas of the state, Baptist Health works very closely with one or more passenger providers. In the southeast, we work with Great Rivers Technical Institute and McGehee-Desha County Hospital in McGehee, Arkansas, the Main Line Health Systems in Portland, and the Jefferson Comprehensive Care Center in Pine Bluff.

In the southwest corner of the state, Baptist Health works with Baptist Health Medical Center Arkadelphia. In the fourth west corner, we work with Boston Mountain Rural Health Center in Marshall and Fairfield Bay in Clinton. In the north central area, we work with White River Rural Health Centers in Augusta and Baptist Health Medical Center in Hebrew

Springs.

Families from throughout the state of Arkansas can use the Baptist Health system through 131 access points across the state. That includes hospitals, surgery centers, physician clinics, wellness centers, community health centers, therapy centers, and home health agencies.

Baptist Health provides state-wide telephone access to health care information and physician referral services through our Baptist Health health line, and emergency medical emergency air transport through Baptist Health Med Flight.

As a major initiative, Baptist Health is currently developing and maintaining community-based clinics, especially in Arkansas's rural health care areas. The people served by these clinics find them to be accessible, comparatively low in cost and sometimes free.

In 2002, Baptist Health's 23 wellness and community health centers provided a wide range of health care services in caring for 10,450 patients visiting those clinics.

In the United Health Group State Health Ranking 2000 edition, Arkansas has the 46th worst record throughout the U.S. for the general health of its

population, and you heard some of that from Kevin.

Since 1990, Arkansas has failed to match other states in improving in the areas of smoking reduction, in risk for heart disease, or decreases in infant mortality. The related factors of low income and obesity are also a major concern. According to the 2000 U.S. Census, the average per capita income in 1999 was $21,587 for the nation, but in Arkansas, it was only $16,904. The Center for Disease Control or CDC statistics show 19.8 percent of Americans are obese, yet it rises to 22.6 percent among Arkansans.

Baptist Health supports programs to address community health concerns. Some of these include -- in obesity, we have weight management programs, in-step walking clubs and diabetes self-management programs. In the area of smoking, we have the, in this case, teen depend answer program and partners for smoke-free families.

In heart disease, we have cardiac rehabilitation, CPR heart saver training, lipids clinic, cardiac risk intervention programs and women's heart advantage.

In infant mortality and low-birth-weight babies, we work through Heaven's Loft Wellness Center, we have a high-risk pregnancy service and a neonatal

intensive care unit.

In the area of pulmonary disease, we have a pulmonary rehabilitation program.

As a core system strategy, Baptist Health's community outreach initiative serves as a catalyst to improving the health and the well-being of our community, and our community is Arkansas.

A variety of programs are offered in diverse settings to improve the health status of our population. These are accomplished in partnership with churches, with businesses, schools, and other benevolent agencies. Some of these partnerships, including Emmanuel Baptist Church and Jefferson Comprehensive Care Center, provide medical care to the under insured and the uninsured citizens. These services are based on the ability of the person to pay, and often the services are provided at no cost.

Another partnership is with First Presbyterian Church and Energy of Arkansas where we provide free health care for the homeless population. A partnership with St. Paul McGhee-DeShay and Greater Second Baptist Church where we provide health prevention activities for underserved citizens. Henderson Health and Science Middle School where we provide resources and opportunities for students to shadow health care

professionals. We also work in partnership with Positive Atmosphere Reaches Kids, a park, where we provide nutrition hot meals for at-risk students in an innovative academic program.

We work with the Arkansas Health Department and the Pulaski County Health Unit to improve the health and quality of life in Pulaski County.

Baptist Health and BlueCross and BlueShield collaborate in the "Partners for Smoke-free Families Initiative," as well as provide disease management programs that compile risk assessment reporting data for low back pain, cardiovascular, respiratory and diabetes.

The greater Little Rock area is served by three major medical centers, four community hospitals, five specialty hospitals, and four psychiatric or drug rehabilitation facilities. There are a total number of 3293 licensed beds in the greater Little Rock area, this includes 2775 inpatient beds, 518 rehabilitation beds. Within a 13-county region in central Arkansas, there are now 28 hospitals for a total of 4730 beds. One of the greatest challenges Baptist Health faces is meeting the health care needs of Arkansans who are without health insurance.

Our state exceeds the national average in this

area with 18.7 percent uninsured in Arkansas versus only 16 percent of the U.S. As you heard earlier, one in five employed people and their families in our state are without health insurance. The uninsured poses a major threat to the continued viability of health systems such as Baptist Health.

Another area of challenge, the shortage of nurses and health care professionals at both the state and national level present major challenges to providing high quality patient care. The availability of qualified health care workers is dwindling, at the same time, our patient population is expanding. In addition to fierce competition to recruit and retain the best care givers, the challenge of staffing will have a long-term impact on the ability of community hospitals to sustain current levels of quality in health care services.

Baptist Health is responding to this challenge by offering free nursing education opportunities throughout Baptist Health schools of nursing and allied health. Baptist Health has encouraged increased enrollments by providing scholarships, loans, job commitment agreements and limited offers of free tuition. So, we believe we're certainly doing our part to address the nursing shortage both in the state of

Arkansas and the nation. As a result, the registered nurse classes in 2003 and then next year will be larger than any of those in our history, including many LPNs who will complete our fasttrack program, leading to RN status. Baptist Health's commitment of resources, the staffing challenges, will help sustain quality of care, as well as fill vacancies in our facilities, but also for other health care providers throughout the state of Arkansas.

Quality: Baptist Health addresses quality on an overall basis by participating in accreditation by the Joint Commission on Accreditation of Health Care Organizations, improved patient satisfaction with the national satisfaction survey, the clinical quality with the Arkansas Foundation for Medical Care through ongoing clinical studies.

The two most common quality of care measures for hospitals are mortality rates and readmission rates. When cases are adjusted for severity, Baptist Health is comparable or below the expected rate among hospitals in Arkansas in both of these categories.

Baptist Health is committed to defining the highest quality care and translating it into routine practice. Baptist Health participates in several quality of care initiatives, here data for diagnostic

outcomes is shared nationwide. These include acute myocardial infarction, pneumonia, stroke, women's heart advantage, and congestive heart failure.

In comparing our clinical performance against national rates, Baptist Health produces high performance outcomes that result in reduced patient mortality and morbidity.

Cost: Baptist Health continue to face a number of challenges with the rising costs to provide care for our patients. Medicare and Medicaid continue to provide reimburse meant at rates less than the true expense of providing these services. Hospitals are concerned that at the federal level, historical increases in military spending, trillion dollar expenditures associated with proposed tax reductions, and funding for expanded homeland security will trigger a new round of Medicare budget reductions.

Private payors are on average only increasing payments by about half of the expense increases we're experiencing. In 2002, Baptist Health experienced a number of operating expenses that increased beyond our control. These included an increase in Baptist Health's portion of employee health insurance, a substantial market adjustment to salaries for our nurses and other health care professionals and 175

percent increase in our medical liability and property insurance.

Just this week, we were forced to announce a nursing salary increase that will exceed $7 million annually throughout our system just to meet market increases from two local hospitals.

We also made a capital investment to expand our nursing schools in allied health so that we could, in fact, accommodate larger enrollments in an effort to address staffing changes.

These increases occurred during a time we experienced a loss of insurance business, and incurred the cost associated with HIPAA compliance, and bio terrorism preparedness. While Baptist Health is experiencing increased expenses, and decreasing reimbursement, we are providing more health care services that are either charity or uncollected debts.

In 2002, Baptist Health provided 68 million dollars in health care services for which we received no payment. Baptist Health's average cost per case is comparable to or below similar hospitals nationally and in Arkansas. Factors contributing to higher health care cost in Arkansas include: Population size, age distribution, personal income, and insured status, or uninsured status.

Arkansas is a predominantly rural state with low HMO penetration and a high percentage of the population age 65 and older. This results in higher hospital utilization and higher personnel or personal health spending than the national average. In Arkansas the social, economic and competitive environment is unique. The fiscal crisis in health care appears to be on the upswing with a number of downgrades in the not-for-profit health care bond market. Those have risen during the third quarter of 2002, despite predictions of stability.

Increasing patient expectations, coupled with soaring expenses, and decreasing public and private reimbursement place pressure on not-for-profit health care systems. Baptist Health has maintained a history of stability despite this precarious environment. The delivery of health care in Arkansas is highly competitive, and promises to change rapidly with the evolution of diagnostic imaging technology and the swift development of new care settings.

Competition from specialty niche providers who provide only the most profitable services will make it more difficult for not-for-profit providers like Baptist Health to serve the community with comprehensive services. In an increasingly competitive

market, Baptist Health's challenges will be to respond to unending pressure to improve efficiency, upgrade our technology, recruit and retain our staff, provide care to an aging population that is growing exponentially and serve the poor and the uninsured, which is growing.

As one of the state's largest tertiary care centers, Baptist Health plays an important role in supporting rural health care. Rural hospitals who are an integral part of their communities are adversely impacted by government payment and regulatory policies. Without the availability of resources and financial support from systems like ours, there will be an erosion of access to care in the rural health care delivery system in our state.

In conclusion, competition among health care providers in greater Little Rock remains brisk. Access to services is improving, but needs to continue to improve for the uninsured. Hospitals are improving the quality of clinical care, even while we're trying to control our costs. Given the competitive nature of our market, community hospitals will be required to intensify their efforts to achieve efficiencies to care for the needs of our patients. In meeting the needs of our patients in a caring, christian environment, Baptist Health is committed to providing access to all

patients, regardless of their status, and working for continued improvement in quality while we try to control our cost. So, on behalf of Baptist Health, we want to thank you for the opportunity to participate in this roundtable discussion today.

(Applause.)

MS. MATHIAS: Thank you.

Jim Kane?

MR. KANE: Good morning.

Little Rock Cardiology Clinic is the oldest cardiology group in Little Rock, and I am the oldest surviving member, although some days I have a question about the latter. I want to do three things this morning, since the hospital -- the Arkansas Heart Hospital, has triggered some of these issues we're here to talk about, I want to review some of the things I think are unique about the hospital. I want to show you, secondly, how some of the ways that the community hospitals respond when a specialty hospital is built in a town, and lastly, I want to give you a short list of the concerns of our group.

Now, this is the Arkansas Heart Hospital, just the other day. It has 100 beds, we usually operate about 84. When I left yesterday morning, we had 85 patients in the hospital, presumably one was out here

under the portico. There are eight emergency room beds, there are 18 outpatient beds, and if we are overbooked, well, we put somebody in the emergency room.

The top two floors are for patient wards, the bottom floors are the surgery suites, the catheretization laboratories. This took me a little bit of time to get used to; these are called pods, and there are seven beds around each pod, and each room, then, is only about 10 steps from each nursing station.

There's no CC U, there's no ICC U, rather each bed is licensed as an intensive care bed, and when we have an ill patient or a recovering patient from surgery, the room is upgraded in terms of equipment and in terms of nursing care. And a desperately ill patient will generally have one nurse sitting at his bedside.

When we built the hospital, the doctors wanted it to be a center of excellence for cardiac care, and we insisted on the best equipment. We have six catheretization laboratories, we have new flat panel technology, we have two EP labs with the latest EP equipment.

I don't know how we did this, but we wound up having one of the first four vascular MRI scanners in

the country through some deal that Mr. Mensura and others worked, and this was continuing to upgrade this, but basically with this instrument, we can make non-invasive images of most of the vessels, and we're getting to where we can make out the coronary vessels.

Now, this technology has been embraced by the hospitals in the state as well. We have the latest in CT scanners, we use this for our heart saver CT calcium screening studies, as well as other routine studies in the hospital.

This is sort of a unique feature. This picture, by the way, has been blurred to satisfy HIPAA. There's no dispatch service in the heart hospital. If a patient is going to the cath lab, if he's going to x-ray, the technicians who are doing the procedure come and get him, take him there and bring him back promptly. There's no waiting an hour or an hour-and-a-half in x-ray. If they need an ekocardiogram, the equipment is taken to their bedside, and it's improved the efficiency of these operations remarkably.

Now, one reason we're able to do that is because the hospital is small, and this is a case where probably small is a bit better.

Our admissions have grown steadily from the

time we've opened and we're now about 5,000 a year, that was last year. We've captured a fair amount of the market share, as you can see, and now we're about 40 percent, that was in 2001, this is from medpar data. We may be a little bit higher than that. We eclipsed St. Vincent's hospital very quickly, simply because our group was primarily based at St. Vincent's when the heart hospital opened. So, when we moved a fair amount of our operation from over there, the St. Vincent's market share dropped considerably.

Let me hasten to point out that although we concentrate at the heart hospital every day of the week, we go to Baptist Medical Center, we go to St. Vincent's hospital, we go to Southwest Hospital, we have patients in all the hospitals in town. But what about the quality? Now, you can look at that several ways, but several of the ways that's looked at is how long are the length of stay, what about the mortality, and are the patients at the heart hospital as sick as patients in other hospitals?

Our length of stay is shorter. Our mortality for these major cardiac diagnoses is less. And our case severity mix is as high or right now higher with more complex cases than these comparison hospitals.

Do the patients like it? They absolutely love

it. This is a telephone survey that we do routinely, when folks are discharged. They like the fact that they get respect. They like the fact that the family is at the bedside, we have no visiting hours, the family can stay as long as they want. They can stay there if the patient is on a ventilator, on a balloon pump or whatever. They don't like the food in the cafeteria.

Importantly, they would come back to the heart hospital 98 percent of the time and they would recommend it to others 98 percent of the time.

Where would you go in Little Rock if you were having a heart attack? Well, while this is a telephone survey, and this in part reflects reputation, it also in part reflects how much money you spent on advertising. A third of the people surveyed would go to the heart hospital, about a quarter to Baptist, less to St. Vincent's, I don't know if Children's Hospital has an occasional heart attack show up, probably not. These don't add up to 100, because one respondent actually felt that he would be better off going to Home Depot.

What about cost? It's hard to gather cost data in the Little Rock market, and I don't have that, but this is a comparison of eight Metcalf hospitals with a

large number of community hospitals for all the cardiac D R Gs, and this is a cost per hospitalization initially as well as out to 90 days. And as you can see, Medicare wound up about $3,800 in the black from these admissions.

Now, how do the community hospitals respond and how do the payors respond? Well, frankly, I would respond the very same way that they have. This is our group in 1997, about on the eve of the hospital opening. Mostly a convivial group, some days they all like each other. Each one of these guys is a superstar in one way or another. Now, shortly after the heart hospital opened, we ran afoul of BlueCross and BlueShield in some areas, and they didn't like us very much, and we were what we call deselected, and we were taken off the BlueCross and BlueShield panels. That was in about 1997 and we're still off the BlueCross and BlueShield panels. Some of our young doctors felt like they just couldn't make it without the BlueCross business and they went elsewhere, and then a minor miracle occurred. Shortly after leaving our group, there they are gone, they were to the BlueCross BlueShield panels. And this had to do with joining other groups in town or in the case of Dr. Norris, moving to Conway.

This scenario has been played out several other times. This was a wonderful doctor, Dr. Paul Rubario, he is a full clinical professor at Yorba Linda University in California. He was enjoying teaching there and taking care of patients and then he got four kids in college. And he couldn't quite make it in California, so he came to the land of opportunity, Arkansas, and he joined another group, not our group, two guys, and he loved his patients, he loved Little Rock, he loved practicing there, the patients loved him. This patient's name is HIPAA. And he got to do some teaching.

He didn't like his partners, and he didn't fit well with them, and frankly, who would have, and he asked to join our group, and we were absolutely delighted, because he's a superstar, and he did join our group, and he's been very happy there, except here he is the day he learned that one of the many benefits of joining Little Rock Cardiology Clinic is that you're deselected from the BlueCross BlueShield panels, at least as of this time. Now, he's doing okay, his kids are still in school, they sort of go every other day, they sort of alternate, but he's getting by just fine.

Now, this is the Heart Hospital a couple of days before we were to have our panel back in February,

and that was cancelled, but about this time, shortly after this picture was taken, I began getting calls. Apparently word got out we were having this meeting, I got some calls from some of the orthopedic surgeons in town who are planning or have been planning to open an orthopedic specialty hospital, and it's upset, Mr. Harrington and others, to absolutely no end, and I only have one side of the story. The other side of the story is here, but the orthopedic surgeons tell me that the Baptist board has voted that if they open the hospital, they will be decredentialed at Baptist Hospital. I don't know whether that's true or not, but perhaps we can pursue that.

This has been done in other towns. Here's an article in one of the trade publications from Ohio where doctors opened a single specialty hospital and they were removed from the staff of the community hospital. So, it's not a -- it's not Mr. Harrington's idea or the Baptist Hospital's idea, it's been done in other places.

Now, this is how they can exert this sort of pressure. They've been amazingly successful. This is a wonderful business plan, and you just heard Mr. Harrington tell you some of the details, but they have either bought or have run hospitals in Arkadelphia,

North Little Rock, Hebrew Springs, this is OCL Blytheville is in there, four cities in there. This is Forrest City. And here's how it works: I used to have a large practice up here in Hebrew Springs, a nice little town up on greatest ferry lake, and then they changed the name of the hospital to Baptist Medical Center. And since I am not a Baptist doctor, per se, although our group is, and since I'm not on the BlueCross panels, the day that name changed, my practice from there dried up like the proverbial well, as long as calls from referring doctors.

Now, let me be very quick to tell you that Mr. Harrington and Mr. Shoptaw are the absolute best at what they do. Mr. Harrington has indeed built Baptist Hospital and Baptist Medical Center into one of the prime tertiary care centers in the country. There's no question about that. Mr. Shoptaw has led BlueCross BlueShield in Arkansas to the height of that organization's stability there, and they've just done very well. I don't hesitate to say that although I've been practicing cardiology for over 30 years and I'm gradually getting a bit better, they're still better at what they do than I think I am at what I do.

Still, you have to worry a little bit about this trend toward a single payor system that's closely

allied with Baptist Hospital. And frankly, where the B is for Baptist, you could substitute Blue. You might worry a little bit about what the M means. Now, I'm not going to use any of the M words, but you know Baptist and BlueCross use software, they don't sell it, and far be it for me to suggest that they change the street and name their offices to Park Place, but you just have to worry a little bit about how large this system is getting.

But you know, we are as happy as we can be as doctors in our group. I think we're some of the happiest doctors in Arkansas, but here's a short list of our concerns. We worry about the dominance of segments of the market by the BlueCross/Baptist alliance. We fret because we're still excluded from the Arkansas BlueCross BlueShield providers, despite the fact that we have doctors who go to Baptist Hospital every day of the week and we have patients in Baptist Hospital every day of the week.

We're concerned because other payors have left the state and because other payors find it difficult to enter the state and go into business there. We're concerned now about what we might call economic credentialing. This is how working at a single specialty hospital might affect the doctor working

there in terms of being credentialed at Baptist Hospital or St. Vincent's hospital, for example. So, a short list of our concerns.

Now, about 25 years ago, my old partner, Dr. Barlow, who has since retired, had a sick patient. She was so sick. And she was not doing well, and he had to go out and talk to the family and give them the bad news. And the family was large, they were from the Hills, they didn't understand a lot of things, and Dr. Barlow said, you know, we have done the best we could, she has been on the balloon pump, she's been on the respirator, she's had bypass surgery and I'm sorry to tell you that your Mama has expired. And they didn't say anything, and there was some murmurs and looks exchanged, and finally one large boy stepped forward and he said, Doctor, we think we understand what you're saying, we just got one question, is it serious? And that's our question for you as I leave here today, are these issues in Little Rock serious, and we look forward to some lively discussion.

Thank you for asking us to talk.

(Applause.)

MS. MATHIAS: Mr. Shoptaw?

MR. SHOPTAW: Very good, thank you, Sarah.

Over the course of the 10 minutes that I have

on the front end of our discussion today, I would like to review a perspective as a major third party payor in the Little Rock market, and let's track through some points here that I've divided into three general areas.

First of all, I would like to talk just a little bit about the characteristics of the Little Rock market that are pretty much mainstream, and probably representative of other MSAs with the same general population base. The second one relates to the attributes of really our state, which I think is materially different, and I would like to focus on those very briefly. And then just some general observations that I would like to add that hopefully would serve for the context for today's discussion.

As has already been pointed out, Little Rock MSA health services market is not discreet, it's really State-wide and multistate in nature. So, anytime you're looking at data, I think we need to understand that there really is a large in-migration of care into Little Rock.

As in other markets across the country, we're seeing a major movement in Little Rock and across the state from the 1990s version of managed care to a lot more open access to specialists, virtually no preventive or preservice certification, I should say,

and ever larger provider panels, particularly as physicians, as we've already heard here this morning, actually migrate from one hospital medical staff to another, and seek entry into the networks accordingly.

We're looking at a shift away from strict HMO offerings to more POS or point of service. Our market is dominated by PPO, and in fact we're seeing some employers actually go back to traditional indemnity. We have a growing interest, as is the case across the country, and a lot of us believe that we really are looking at a paradigm shift in terms of a new generation of products and services around defined contribution, which Joe Meyer spoke to, and generally consumer-directed health care in the form of medical savings accounts, section 125 and section 105 types of benefit structures.

The nature of the competition in the Little Rock market, I think, is very typical of others across the country. We really have a continuum, we have the traditional multiline carriers who basically provide all different product types and heavily rely upon scale economies and standardization of product offerings as competitive edge.

On the other end of continuum, we have specialty or niche competitors that really

differentiate themselves by focusing on only certain products. They have lower price in terms of lower overhead, greater product flexibility, they're highly individualized in many cases as far as customer service, and they provide or may have unique provider affiliations or sponsorship. And then, of course, a lot of competitors in between those two ends of the spectrum.

In Little Rock, we have the big three national players, Aetna, Cigna, United, all of which have in excess of 15 million enrollment across the country. We have two large local health plans, that being QualChoice and BlueCross Health Advantage. We have 64 in-state and out of state TPAs that compete for the 45 percent of the market, roughly, which is self-funded, that is the larger employers under ERISSA, basically self-insured. We have seven state-wide provider rental networks. We have two unbranded out-of-state BlueCross competitors, that being WellPoint through Unicare out of Texas and then HealthLink out of St. Louis BlueCross that participate in our state.

It's interesting to note that we have 168 licensed insurance companies that are marketing policies in our state that have a corporate annual premium base of over $100 million; of course, that's a

multistate basis. The largest private employer in the state of Arkansas actually self administers its own claims and uses a rental network as opposed to being fully insured.

The second largest private employer in the state actually maintains its own provider network. It has direct contracts with hospitals and physicians, and then it uses third party administrative services with a national health carrier to administer those benefits.

And of course, as I mentioned earlier, we have entry of a number of the newer .Com types of competitors such as Infinity and Lumenos.

Looking at the characteristics of the Little Rock market, there is no direct ownership of physician practices by health plans, although a number of hospitals do have ownership of physician clinic practices. Reimbursement, as you might guess, is largely discounted with fee for service with DRGs and per diems, and in our state, we never really saw a large groundswell, if you will, of pure capitation. And, of course across the country, pure capitation is basically diminished over time.

QualChoice and Health Advantage are IPA network models with equity ownership by both hospital and health insurers. United runs an IPA network, but with

no equity, it's a traditional relationship, as is Aetna and Cigna, both of which primarily focus on the PPO types of products for both insured and the large self-funded employers.

Kevin has already talked about the features of our market where we have a very heavy disease burden. Obviously, that translates into higher per capita cost. You've already heard about the uncompensated care in terms of not only low reimbursement for Medicare and Medicaid patients, but the fact that we have a high percentage of our population that are eligible for those two public sector programs. And, of course, with a low per capita income, the ability to collect debt in terms of services at the individual household level is very difficult.

The good news is that based on Milliman data if you take a standard PPO benefit package and compare the PMPM or per member per month rates that we're charging in Little Rock, at least for BlueCross product, we're 13 percent below the national average for a comparable set of benefits.

Looking at the way that our market breaks down as far as health insurance categories, as you might expect for the under age 65 insured and self insured markets, there's a wide variety of HMO, PPO, indemnity

and any willing provider types of options. Medicaid actually runs its own managed care program around a primary care model, which is AWP oriented and discount fee-for-service. Medicare, of course, has the standard package, and there are a few Medicare plus choice options in the state. There are no HMOs, they're all basically indemnity-based PPO Medicare plus choice options.

And then CHAMPUS has 50,000 people in the state that's administered through health net, which is a west coast PPO.

If you look at the billable dollars, you get some idea of just how dominant Medicare and Medicaid is in the state. Out of 15 billion dollars annually, about nine-and-a-half billion in terms of billable services on a ratio basis align with Medicaid and Medicare. And as indicated here, the Little Rock market, the four counties consume about 20 percent of the total health care resources on a state-wide basis because of the population concentration.

Physician cross participation is very high in our market. For example, in our networks, 40 percent of the physicians that are in network or HMO or PPO actually participate in other competitive plans. We have no exclusivity in any of our contracts, so it's

strictly up to the hospitals and physicians to decide who they want to participate with.

In rural markets across the state, particularly those that have a single hospital, almost without exception, if there's one hospital in town and three primary care physicians, if you're going to have a PPO or HMO, then every health plan has to contract with those providers. So, you essentially have cross participation on 100 percent basis.

The final point and one that's very important that hasn't been touched on much so far in the panel, is that we do have the standard consumer safety nets in place. We have a high-risk pool for the otherwise uninsurable population that can't get private coverage otherwise. We have a guarantee fund to protect against insurance company bankruptcies or insolvencies. As indicated in the note, the funding for those two features basically come from assessment from health insurance plans.

Please note that the roughly 40 to 45 percent of the market that is self-funded under ERISSA, that those employers do not participate in funding these type of safety net programs. This is basically from fully-insured individuals and small businesses that are too small to self-fund.

With that, that concludes my remarks. I very much appreciate the opportunity of being here today, and as Dr. Kane suggested, I'm looking forward to our discussion accordingly.

MS. MATHIAS: Thank you, Bob.

MR. SHOPTAW: Thank you.

MS. MATHIAS: John Wilson?

MR. WILSON: That was good, Bob.

MR. SHOPTAW: Thank you.

MR. WILSON: There's bad news and good news. The bad news is this is the first week of turkey hunting; and bad news: I take a week's vacation every year to celebrate that. The good news is two days ago two of those critters gave up the ultimate sacrifice, so I'm glad to be here.

We were given an outline of questions that were pointed toward doctors in a questionnaire, and I would like to go down that and make a few remarks in regards to the questions, and then make a few general remarks.

It said what constraints are placed on doctor community by health plans. Well, we're told where to practice and we're told with certain restrictions as to what we can and cannot do. Are these constraints expressly spelled out with contracts? Yes. Do physicians perceive constraints because of health plans

that include, without cause, termination provisions? Certainly they do.

To what extent do these constraints based on quality of care considerations versus administrative? Both. As physicians, we have an oath, and we do our best to take care of our patients based on those oaths. We also are business people, so we have to balance these two issues. How much integration has there been in my region? A bunch. I'm an orthopedist. There is one solo orthopedist in the city of Little Rock, to my knowledge, one.

What are the positive results? Well, with decrease in what we're paid for our time, and with an increase of what it costs to do business, our spendable income has decreased, particularly when you get to be an old guy, because you can't increase volume. There's not enough energy.

So, what do you do? You get into services that Mr. Harrington has provided over the years, you get into buying MRI machines, you get into surgery centers, you get into physical therapy. What we're doing is we're getting into ancillary activities in order to maintain our standard of income and living. It's a very simple thing you do.

What are the negative results? We're getting

into areas that we're not trained to do. We're trained to be doctors, we're not trained to run large corporations, and that's what you get to be in. So, these are the negative things.

Are there solo practices in the market, as I said, not many, and how they're doing, they're doing poorly. Do they occupy a particular market niche? Sure. They provide services for people in car wrecks, they do disability evaluations, and they take care of certain Medicare issues, but indeed, they are not what I would consider competitors in my market.

What risk do doctors assume practicing in Little Rock? No more than any other place, I would assume. Do you think these risks are similar to those faced across the nation? The answer is yes.

Is there evidence that reduction in provider reimbursements has harmed the quality of care? Sure. If indeed you spend less time with individuals looking after them, you can't provide the same quality of care as you did when you could spend more time and get paid more for your time.

Should the standard of care for determining minimal appropriation variable of quality be determined solely by reference to professional standards? And I think what they're talking about here is algorithms.

There's a yes or no answer to algorithms. Algorithms, I think, are particularly helpful for those individuals in training, and those individuals who have less grey hair, I guess that's the way to put it.

They take the art out of medicine. They put in a great deal of testing without thought. So, I think algorithms that are used by themselves are not good all the time.

Would an aggregation of market power by providers have net benefit or cost? I think if you give -- if you give people who provide medical care the opportunity of charging more for their services, they will. I think if you decrease the amount a person can make for their time, then they tend to spend less time in doing what they're doing, so you decrease the quality of care and those issues.

If the providers raise their prices, who will pay for the health care cost increase? The consumer. The consumer pays for everything, one way or another.

Does the reverse also hold that should health care plans be permitted to acquire power in response to possession of significant market power by providers? If you own a doctor, a corporation, it is my perceptive that you have less production from the doctor. Look at your VA systems. People who work -- physicians who

work as a salary, working for a corporation, tend to get the pencils on their desk at 3:30 in the afternoon, and line up. People in my business are still there at 6:30 competing.

So, if you take away the competition, or their ability to compete, then you take away a person's wanting to produce.

Just as a recipient of Medicare for over a year now, let me ramble for just a minute. I have been in practice 34 years. My hat has changed a number of times over those times. I find myself wearing more than one half now. When I started, I was a simple doc in a fee-for-service type of situation. Medicare had just really started in. Medicare was poor -- not ideal -- but a poorly made-up event.

It did not have means testing, which it should have from the start. It did not have prescription benefits, which it should have from the start. But the big thing is that a lot of people got something for nothing that they were paying for for years. They rationed the use of a particular product because it cost money, and as a result of the product not costing money, they overutilized it. There were not constraints placed on physicians as to what we charged initially, so we overcharged quickly for the services

that we provided. As a result, we have all sorts of constraints that have been placed on us, and so it's going back the other way to the point that we've got a system that is failing just because you can't pay for it now.

Managed care has come along, and you -- and with managed care, you have dissolved the doctor/patient relationship. In a fee for service business that I started with, if a person came to my office and I saw that I wasn't going to gel with this individual, I could in a nice sort of way send them on their way. Or if a patient wanted to come there -- if a person wants to come to see me now and they're in a certain HMO, they can't do so, they have to see someone else, or in a worse situation, someone has to come to see me, they want to see someone else, and they don't trust me, because they don't know me.

So, the doctor/patient relationship has suffered. And as a result of that, this's more liability, as far as practicing medicine.

We have worked -- one of my hats is I'm president elect of my state medical association. We've been involved with court reform, because our malpractice insurance has just completely gone out of sight. And we were able to get some of that. We have

been attempting to get something done federally for years, but our Senate continues to refuse to consider dealing with this issue.

Competition in medical care is good to a point, as long as you can make profit. If indeed you're competing for something that is not profitable, then it's not a good thing.

Thank you.

(Applause.)

MS. MATHIAS: Thank you. We will take about a 10-minute break, and then reconvene for the moderated questions.

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

MS. MATHIAS: Well, I think we've hit about our 10-minute mark. So, I would like to go ahead and get started. One of the things I think that we probably all noted from this discussion is that when you look at Little Rock, you have to look at the entire Arkansas state, which is an interesting revelation, I'm sure, for everyone at least outside of Little Rock who is listening, so it's been great insight already.

Ed and I will exchange and ask a number of questions of you, and again, if one of our questions elicits further comments and such, feel free to turn

your tent. Before we actually start with the questions period, a lot of comments have been raised, and for some of the people at the beginning of the panel who may have heard things that they want to respond to, I would like to first start with that opportunity and then Ed and I will move into the questions.

So, I'll just go down the row, and if you don't have anything right now, that's fine. So, Kevin?

MR. RYAN: I think one of the points that you mentioned I think is very key, the fact that while we're looking at Little Rock specifically here, you cannot look at it in a vacuum. I mean, I think that's true of all the comments that were made here today. It was definitely true when we examined the health insurance and health care marketplace in the state, that it's inextricably linked with the entire state. It's both the advantage and disadvantage of being from a small state like Arkansas. But you cannot -- you cannot look at it in isolation. What happens in each of the four corners affects Little Rock, and it's definitely an interesting and ongoing type of association that has to be examined.

MR. BATES: I would just make one observation about Kevin's comment about the number of people who were admitted without insurance. We know that in our

hospital, if you get admitted without insurance, it runs about 10 percent, but discharges without insurance is only about 3 percent. So, we use that period while we have them to get them enrolled or to make sure they do get some insurance because a lot of people don't know how to do that sometimes and they're eligible for Medicaid. So, another parameter would be to look at the discharge percentage as well.

MS. MATHIAS: So, they get enrolled into Medicaid or is it Medicare?

MR. BATES: Or it could even be that they have employment opportunities at work, they just didn't take advantage of them.

MS. MATHIAS: Russ?

MR. HARRINGTON: I have nothing at this point.

MS. MATHIAS: Jim?

MR. KANE: I just want to take the opportunity to disagree quickly with Dr. Wilson. First of all about turkey hunting, for those of you here who haven't been, that little notice they put at the bottom of movies, "no animal was harmed in the making of this movie," does not apply to turkey hunting.

Secondly, I take issue with the fact that doctors get into ancillary services and build heart hospitals because of the income opportunities. And let

me quote just quickly from a January Journal of American Medical Association article, it says, "Rather than declining income, physicians are dissatisfied because of the ability to manage their day-to-day patient interactions and their ability to provide high-quality medical care," and that seems to be the source of more of their frustration than simply a decline in their income.

MS. MATHIAS: I think that has raised a response real quick by John and then we'll go back to Bob.

MR. WILSON: Jim, I did not mean to imply heart hospitals specifically, I was talking about ancillary services such as small surgi centers and MRIs and physical therapy. So, that's what I meant as far as the ancillary services.

MS. MATHIAS: And actually, if you don't push the button it will read, and if you do push the button, I think it mutes the microphone.

MR. WILSON: Sorry about that.

MS. MATHIAS: Bob, did you have anything else?

MR. SHOPTAW: No, I have nothing at this point.

MS. MATHIAS: Ed, did you want to lead off with the first question?

MR. ELIASBERG: Okay. In prior parts of the

portion of the hearings, we've heard some discussions about the concept of economic credentialing. And indeed I think we made a little bit of allusion to it here, the possibility or suggestion of the possibility of it in Little Rock also. So, I guess the first question I would like to ask is basically Mr. Harrington, let's start with you -- from the perspective of a community hospital, a nonspecialty hospital, but a community hospital, what are the pros and cons, as you see it, with respect to the notion of economic credentialing? And indeed, maybe we should start out with just your understanding of what that term is and then what you see as the pros and cons to that.

MR. HARRINGTON: Sure, I would be glad to try to respond to that. First to say that as of today, at least, we don't do economic credentialing, but I'm sure glad that Dr. Kane gave me the idea, because we're going to go back and look at it. I like to think of it more in terms of conflict of interest credentialing, or community credentialing. I think the purpose of it, as I've studied it, because a number of my colleagues were doing that, and court rulings have been supportive of it and the American Hospital Association has studied it and taken the right position, I believe. The concern

comes from the community hospital's perspective whose commitment is to that community, to provide all the services that are needed.

Anytime you have an erosion of that, from whatever source, whether it be a physician, whether it be a niche hospital of a specialty nature, those accumulate over time and it reduces the ability of the community hospital to continue to support the community at the level that they have in the past, and they hope to in the future. And in fact, in some cases, it's even threatened their viability.

So, you know, it's easy to say, you know, there's one niche provider, and they couldn't hurt you that much, and I think that's been the case in Little Rock, when you reference the Heart Hospital. We've never attacked them or tried to disparage them, but I am concerned about more. I am concerned about the proposed spine hospital, back and spine hospital that was referenced earlier.

We can't afford to continue to lose a percentage of our volume and thus our revenue, and be able to provide the same quality level of service that we provide and be willing to continue to support whatever the community's need, and wherever -- whether they can pay for it or not, if we continue to be niched

away. And the services are picked off.

I am as concerned about physicians going into traditional hospital businesses and taking those revenues as alluded to earlier, by Dr. Wilson, as niche hospitals, but certainly niche hospitals are going to be a problem, and we, if for no other reason than just good business, we're going to look for ways to try to thwart that in our communities.

MR. ELIASBERG: Maybe just a follow-up question on that. What perspective or observation, if any, would you care to make from the point of view of the Arkansas Children's Hospital?

MR. BATES: Well, of course in our situation, we don't really have much of a problem in this regard, although as I mentioned in my remarks, when the Heart Hospital did open, the stirring about of people with cardiac credentials, nurses, cath lab techs and so forth, as they went into that line of work kind of rearranged the market in our city, and some of that affected us.

I think the issue is almost more that the community hospitals, our hospital, the university hospital, we all assume and shoulder our fair share and a lot of times it feels like more than our fair share of sort of social responsibility to our community. I

think we're concerned that if we abandon that and just focus on certain areas or certain scopes of service, from a strictly business standpoint, it would be a different playing field. It's not even a question of a level one, it's a whole different playing field. And so we're in a situation where you might get competition going between two different sets of rules, you know. I understand that investment strategies and whatnot for places like the heart hospital, it's a whole different approach to how this happens, but at least with a difficult meshing of those two in a community.

MR. ELIASBERG: Just one thing, if you could also comment on, on the national level, with respect to children's hospitals, has there been a development of -- or a trend toward economic credentialing with respect to Children's Hospital, because I think you mentioned that at least nationally that you're beginning to see community hospitals beginning to offer some -- trying to get more into pediatric services. Has that been something that has been occurring?

MR. BATES: No, I don't think so. And if I said something that led you to believe that the community hospitals were getting into it, I did not mean to say that.

MR. ELIASBERG: Okay.

MR. BATES: What has happened, though, is in a number of places where they have not consolidated their pediatrics, they have done so. New York has finally gotten around to doing that. Many states do it, it's a sensible way to get efficient outside out of a critical mass of people. So, scope has been relatively constant over the years, and I don't think you'll see a lot of the economic credentialing or subniching within pediatrics, if you will.

MS. MATHIAS: Dr. Kane, one of the concerns raised by the community hospitals, Baptist and Children's, was the level of indigent care that they need to meet and I was wondering how Arkansas Heart Hospital would respond to that, the level of their indigent or undercompensated care.

MR. KANE: It's been shown basically around the country comparing all the heart hospitals with community hospitals that because these hospitals, including ours, operate a full-service emergency room, where all comers are done, basically, that the level of core provided to the indigent population and to Medicaid, for example, is about the middle of the road compared to community hospitals. I don't have specific numbers, but, you know, we don't turn away anybody at the hospital.

We specifically, and this is always a concern for the community hospitals and specialty hospitals, there's no what's called cherry picking. That's taking the best cases, putting them in the heart hospital and sending the sickest, most indigent patient to the community hospital. We don't do that. You know, I want my sick patients in the heart hospital, I can take care of them better there, that's where they're put, and we never turn anybody away. So, we're about the middle of the road at taking care of indigent patients.

MS. MATHIAS: Bob, a quick question for you. If you look at the slides that Arkansas Heart Hospital put up, and it looks like the length of stay is less at Arkansas Heart Hospital, the mortality rate is strong, and/or good for the consumer, and I'm just wondering when you're making decisions about who to include and who not to include, I don't want to get into proprietary information, but how do you weigh the quality of care being provided by the different physicians and different hospitals in determining whether or not they should be in or out of the Arkansas BlueCross BlueShield plan?

A. Well, in terms of looking at that dimension, a lot of it really relates to the reps that historically have been put in place, and then quite frankly whether

or not there is a need in terms of access for additional capacity.

By definition, an HMO and a PPO really revolves around the proposition of essentially, if you will, sizing the demand that you have for a particularly enrolled population, vis-a-vis then the access to both primary and secondary and tertiary care.

The other side of that is that if you open up an HMO or a PPO to any willing provider, then why should you have a provider willing to give you deeper discounts or go at risk in terms of assuming DRG reimbursement and so forth, if, in fact, you can't channel volume into that particular campus.

So, that's the thing that you have to look at, and then you basically say, look, the heart hospital participates with United, why doesn't United and the heart hospital and the other providers basically take market share from BlueCross? And that's done every day. It goes both ways. But to have a proposition that you just automatically start including everybody under the umbrella, then you basically have moved from really a discipline managed care environment back to really a Willy Nilly provider and an empty base type situation whereas a third party what I do is I just basically sign everybody up and as costs go up, I just

pass them on to the consumer and, you know, I'm not sitting in a panel like this trying to explain what managed care is.

MS. MATHIAS: And I just got passed a note to make sure everybody is talking into the microphone, so raise that and then ask Ed to go to the next question.

MR. ELIASBERG: I would like to key off something that Bob Shoptaw just said and ask a question of Dr. Kane. Sometimes when we're doing the work we do here at the agencies, we hear folks tell us when looking at health plan mergers or health insurance mergers, oh, doctors can fairly easily get their patients to switch health plans. So, if it's a situation where, for example, one health plan will not recognize the Arkansas Heart Hospital, then what will happen will be while there may be a shock there for at the time of announcement, basically the doctors can influence, persuade, their patients to switch plans that do have Arkansas Heart Hospital in their panel, and that takes care of the problem and you shouldn't be worried.

And I guess I would like to ask you, you down there in the trenches, for your thoughts on the validity or accuracy of that way of thinking.

MR. KANE: Ed, I wish we had been able to do

that. At first when all the managed care plans came into effect, I felt for sure that our patients could stay with us regardless, that we could see them for their out-of-network benefits and they would accept that. And you know, it's not fair to them, and frankly, the costs are such that they don't do that. We've been, frankly, I don't think I've ever suggested to anybody that they switch health care plans, per se, so that they can see us.

I will tell you that one of the ways that I recently ran a bit afoul of BlueCross BlueShield is they didn't think that we were following the letter of their contracts early on. We would put patients who were out of network in the hospital, and we actually fixed it so that their out-of-pocket costs were no greater than if we had put them in an in-network hospital. And BlueCross and Baptist Health said they hated that, and that's about the time, I think, we were decredentialed, and that being one of the reasons. And we probably violated the spirit of those contracts.

We have not been very successful in getting patients to switch health care plans, and nor have I really suggested that. I used to tell these folks that I would see them for nothing in the office and we've been seeing a long time, but that just doesn't work

well, particularly if they have to go into the hospital. So that if a patient is out of network and it looks like it's going to cost him a lot of money to come see us, we refer him to an in-network provider. And I think that's fair to the patient.

MR. HARRINGTON: I would like to make one response. I had early on when the heart hospital was under construction, I had a lengthy discussion with the head of Dr. Kane's group, and talked to him about our HMO at the time, and his response to me was the doctors in his group had no interest in participating in any managed care efforts, and in fact, that was one of the reasons they were supportive of building the heart hospital, and in fact, were investing in it. They weren't interested in managed care.

So, it's interesting now to hear about all the efforts they've made over the years, most of which I'm not aware of, to become a part of the managed care that we're involved in. That was something that they were totally against at the beginning.

MS. MATHIAS: Okay, to change the direction of the conversation, one of the items that John Bates discussed was the rising care of -- rising cost of health care, and he wanted to address that later and I would like to raise this opportunity to him, as well as

to Kevin, to discuss some of them. Clearly, the uninsured and the undercompensated is a concern, but I'm interested in what other factors are contributing to the rise of health care costs, at least in Little Rock.

MR. BATES: Thanks. I appreciate the opportunity to speak to that point, just for a moment. We obviously know about the uninsured issue, we know about the question of competition or lack of competition as a driver, but I think there are others, in my mind, that are perhaps more important than any of those. And they would be -- I have a list of four: Regulation is number one, and Dr. Kane's remarks about HIPAA got a big laugh because it's so painful to many of us in so many ways. And that's just one of many regulatory impositions we get. If you're a manager at our hospital, for example, the HIPAA officer comes around and tells us what to do.

The compliance manager comes around and tells you what to do, the safety officer comes around and tells you what to do. Your manager comes around and tells you what to do, and the poor local manager is having a terrible problem trying to figure out how to interpret and integrate all of these rules and regulations because they're mandated in such a highly

structured way and such a pro-descriptive way that there's no latitude on how you deal with them in your individual hospital.

So, to me, this whole trend towards a new regulation and a new so and so officer for each little part is really getting to be very challenging and very expensive. We're today, or yesterday, mailing out 60,000 privacy notices to our patients, and they, like I think all of us, take them and throw them away, when you get all those privacy notices, but we're required, A, to keep track of which ones we sent, B, to include in there a response from the patient, or the family, if at all possible, and C, we have to maintain the database and port on expended and who and what our payors are and so forth, none of which as I can see is making anybody better from a health standpoint. So, that's regulation.

Number two, pharmaceuticals and pharmaceutical costs. One of the drugs that we use in our neonatal ICU is called nitric oxide, it is the simplest imaginable molecule in the world, one nitrogen and one oxygen. And yet, we're obliged to pay for that at a rate that costs us somewhere north of $5,000 a day to use this drug, which is very effective, very safe, and very dramatic or something premature infants.

There's a Harvard professor has the patent on this thing, on the manufacture of this drug. I can go buy a tank of nitric oxide down at my friendly welding shop for about $200 bucks, but I can buy a tank one-tenth that size for $25,000 if I buy it on a medical basis.

So, this personally drives me crazy. I think it's one example of the pharmaceutical side of the house is very severe.

Russ mentioned wages. I think that would be my third topic is wages. Today in Little Rock if you're a relatively bright individual and you graduate from college, and going into something like accounting or some such thing, you could easily get a $50,000 job or better. If you graduated in a four-year school as a nurse, your entry-level pay is more in the range of $30,000 or $35,000 a year. You get to rotate shifts, you get to work with people with fatal diseases. You're at the mercy of the system, as opposed to having a nice, clean, 9:00 to a 5:00 job in an office. I think until that gap closes, we're going to continue to see pressure on wages, and if you want to imagine what happens if you take all the nurses in America at $35,000 a year and bump them up to $50,000, what that would do to inflation and medical profiles and so

forth. It's kind of a terrifying thought, and I didn't even touch on all the rest of them, the pharmacist, the respiratory therapist and the like. And so I think we have more pressure coming around wages on that side of the equation.

And then lastly there's technology, which is unstoppable in so many ways. There's something out there that gives you another 3 percent or 5 percent advantage, it's very hard to say to a family or to a patient or to your board or to your medical staff that you are not going to go that extra step to get something that makes a difference.

In the end, so many of the advances that we have today are an accumulation of this 3 and 4 and 5 percent here and 3 and 4 and 5 percent there and you wind up with 20 and 30 percent improvements which are so important.

So, to me those are the four drivers: Regulation, pharmaceuticals, wages and technology.

MS. MATHIAS: Kevin and then Russ.

MR. RYAN: Let me echo some of the things that John said, as well as my earlier comments, and I think I agree with his listing. I think unreimbursed care, the high rate of uninsurance in the state clearly is a cost driver for the individual, for the family, for the

health care provider, for the health insurance carrier, for the entire system. And as our new data shows, inpatient care alone for 2001, there's almost a quarter billion dollars of unreimbursed care that the system has to absorb. And as I believe Dr. Wilson said earlier, ultimately, that goes to the entire system to the consumer, driving the cost of health care up, health insurance premiums up, you know, it's an entire systematic cost.

Second, as we talked about earlier, the ill health of Arkansans, and related to that, the lack of preventive care that Arkansans get. Clearly, this is both an economic as well as a more personal health cost to the individual and to the family. And again, that's related to the high rate of insurance, all of these are linked together, none of these cost drivers exist in a vacuum.

I think fourth, as John said, prescription drugs. We enjoy in this country, you know, some of the finest prescription drugs in the world that we've achieved through the use of technology, the use of development by pharmaceutical companies, but oftentimes, it's not the latest and most advertised drug, it's not the little purple pill that you see advertised on the news every afternoon that perhaps may

be the best and the most cost efficient drug for a patient to use.

And so, I think it's there clearly is a need for enhanced patient/physician relationship, patient education, to know what is the true cost impact of using different drugs. If a patient can go in and ask for the latest greatest drug, and if there's not a cost element involved either to the patient or the physician, I think that has to be part of the discussion. Not necessarily as a penalty, but it is an education component so that, again, patients and physicians and health care providers understand what that brings to the table as well.

And finally, technology development, again, as a cost driver is so important. Little Rock, like the rest of the country, is seeing the need for and the availability of increased technology. You heard references, Dr. Kane talked about the -- their cath labs. I've seen those, those are wonderful cath labs, with flat screen technology and the latest devices.

We have increased penetration in Little Rock of PET scanners, for example, Posytron emission tomography scanners, which bring an ability to image the body in a different way and look at pathologies in ways that are just now available in the last few years, even though

we've had PET scanners for a number of years. This is very important technology, and it's life altering and life-saving technology, but again, it's -- the cost impact of it oftentimes is enormous.

All of these things, all of these things exist together and are linked together.

MS. MATHIAS: Russ?

MR. HARRINGTON: I agree with all of the items that have been mentioned, and I will try to avoid going through the same ones, except for maybe an example or two, but one that has not been mentioned are insurance fees. Here we're talking about malpractice and liability insurance.

We had a 175 percent increase. I mean, we are now paying premiums for not health insurance, but malpractice and liability insurance in excess of $6 million a year. Just three years ago that was $2.8 million. That's phenomenal in terms of the increases. And we're doing nothing different. In fact, our quality is higher than it was back three years ago.

So, that's one thing I want to mention.

On the technology, just to give you one example, you've probably read about or heard about a product that's fixing -- just getting ready to be released called drug-alluding stints. Stints are those

things that they put in blood vessels to improve your heart, the blood flow to the heart, and we do so many of those, every day.

It's been proven that there's a tenfold improvement in restenosis if you use a drug-alluding stint. While in visiting with our doctors, they tell me that whether they think the patient needs a drug-alluding stint in the future, because of the pressure on them from liability and pressures from consumers who will learn about drug-alluding stints, everybody who has got to have a stint is going to want a drug-alluding stint, or a drug-coded stint to keep the restenosis from occurring.

And the doctors tell me, they'll probably have to put in 100 percent of their patients a drug-alluding stint, in the future, when they become available. Well, that drug-alluding stint costs three times what a regular stint costs. And we barely recover today the cost of a stint under a Medicare DRG.

So, that's just one example of new technology, along with all the other machines that we all have to have to take care of the needs of a much more highly educated general public who wants the very best. Whether they can pay for it or not, they still want the very best.

And I wanted to just give you a little bit more information on this -- the cost of the work force Dr. Bates just talked about. Increasing salaries and benefits. Prior to the year 2003, over an 18-month period of time, we spent $15 million on market adjustments. $15 million that we hadn't planned or budgeted.

Now, these aren't regular salary increases based on merit that all of our employees get, these are market adjustments because the salaries in our market went up, and in order to stay even with the market, we had to spend $15 million just to raise our salaries to cover the market increases.

I mentioned in my remarks earlier, since the beginning of 2003, and just recently, we've had to announce another $7 million worth of market increases again just to stay up with the market. Not to try to leap ahead of it. But $7 million was not budgeted, it was not planned. It will really be felt financially in our organization.

So, those areas that you've heard about are real cost increases, and they're severe, and they're getting more so each year.

MR. ELIASBERG: Actually, this question, believe it or not, Joe, is for you, and if you could

just provide us maybe just a little background information. In your presentation, you listed the company monthly subsidies that you were paying. What I was a little unclear on from it, was that just for Little Rock or was that across your entire company? In other words, you pay the same amount for other cities that you're in?

MR. MEYER: That's a good question. We do it, that's a national subsidy. And as I said, it's independent of health care costs in any one region or location.

MR. ELIASBERG: Okay. Let me ask you, just for my edification, how does it stack up, Little Rock versus some other locations which you have employees? That is to say, looking at the employers' monthly contributions for both served single and family coverage, we see the numbers for Little Rock. How is Little Rock stacking up with respect to some of the other cities in which you have large concentrations of employees?

MR. MEYER: I can give you an example, just from that schedule, the PPO and the first HMO that are on that schedule are national plans. So, those contributions are paid by employees in Little Rock or by employees in any other state or location. The other

two HMOs in terms of -- are the local HMOs, and their costs are probably at or below what we see in other locations.

I think in my remarks, I indicated that the cost in Little Rock, for Little Rock HMOs, are slightly below where we see in other locations, but the premiums are accelerating at a greater rate each year.

MR. ELIASBERG: Let me just do another follow-up question on that, what issues are presented, or what consideration might have been given to perhaps cutting down on the number of possible HMOs that are candidates and hence trying to drive more volume to an HMO with the chance of perhaps getting a better rate, how realistic a scenario is that for an employer with the characteristics of your company?

MR. MEYER: Well, our approach at ALLTEL has been to have competition, and to have competition that the employees participate in. So, we always try to have, in addition to our national plans, at least two local HMOs. We know that we could probably get a little fractional better deal if we were to say to one of those local HMOs, we'll give you all of our business, but we would rather have our employees make that selection based upon the provider networks and hospitals that are in the area. And it works quite

well with us.

MR. ELIASBERG: And one last thing, Joe, you probably said it in your comments, but just to refresh my recollection, the trend over time, are most of your employees going to one of the HMOs or are they staying with a PPO or what?

MR. MEYER: That's a good question. And it varies by market, but in Little Rock, most of our employees are choosing the lower cost to them HMOs, rather than our national plans.

MR. ELIASBERG: Okay. And so the PPO is actually losing enrollment to an HMO?

MR. MEYER: Well, yeah. If you're just looking at Little Rock.

MR. ELIASBERG: Just Little Rock, right.

MR. MEYER: The PPO does not have many members in it in the Little Rock market.

MR. ELIASBERG: And just one follow-up question, the HMO that they're losing enrollment to, the panel structure for that, how much selectivity is there? That is to say, how much restriction is there upon or what -- can you give us some primers on who is not on the panel, how restricted it is?

MR. MEYER: Well, the two local HMOs are Health Advantage and QualChoice, and so the employees are

making their decision based upon -- primarily based upon the hospital. The Health Advantage, as Russ indicated, is part of the Baptist network, and QualChoice is UMAS and St. Vincent's. The providers -- the physician panels are similar in both locations, because most physicians practice at both Baptist and St. Vincent's. There's quite a bit of overlap. So, they're primarily picking it on contribution, and but I would also say that there is with employees, there are people that prefer Baptist and there are people that prefer St. Vincent's, but I will say even with that preference, they generally go with what's going to hit their pocketbook.

MR. ELIASBERG: Sure, thank you.

MS. MATHIAS: I am going to throw this question more out to the panel as a question question, hopefully I will get a couple of responses. It's always a risk to do it this way, but one of the areas that we're interested in is how much information the consumer or the patient is able to get about the quality of service or the quality of care that they're going to get from a hospital or from a physician, and one of the things that I received right before the -- what was going to be the February 28th panel, was the Little Rock Monthly, and they actually went through and ranked some

of the doctors and the care that was given.

So, there is some of the quality information that may be getting out to the consumers, although I don't know the background in how they were actually chosen for this magazine, so it kind of makes it a little different, but what I'm wondering is, some of the quality -- you know, some of the initiatives that the hospitals have taken and the doctors have taken to improve their quality, and then are they getting that information out to the consumer/patient so that they can make a better informed decision about their health care?

And I'll just open that up to whoever wants to turn their tent over to answer, if anyone. I think Kevin turned first.

MR. RYAN: I think historically, the wisdom was that quality was assumed. I mean, in times past, it was assumed that all health care providers provided the highest quality care that you could assume as a purchaser either at the employer person level or the employer level, that you would be receiving, you know, top quality care. I think that assumption is still valid, but consumers and employers as consumers, are looking at those issues now.

There is oftentimes a lack of availability.

There have been some national efforts, NCQAs Quality Compass, for example, has collected information over the past number of years and made that information available.

In our interactions with Arkansas consumers, we're finding that the assumption that quality is there is still oftentimes the case, that many times employers and employees, as Joe alluded to, are looking at cost. I mean, cost is oftentimes the driving parameter, and then quality is assumed, while perhaps looking at more specific services.

I think there is a need for increased availability of quality information for all purchasers.

MS. MATHIAS: Jim?

MR. KANE: Well, I think a lot of that is word of mouth and personal experience. Now, St. Vincent's is not represented here today, but let me just tell you that if I have a patient in my office who has been to St. Vincent's recently, where I must tell you that the quality of care in some areas has declined just enormously, even if they've been in the heart hospital, it's just absolutely astounding the differences they report.

So that just word of mouth reputation among patients, families, and consumers in general, I think,

is the best way they get the quality issue.

The financial issues, I think it's kind of interesting, over the five years that the heart hospital has been opened and that we've been investors in it, I've had one patient who owned the heart hospital, and that was a developer who thought he might want to do a similar project himself.

Frankly, they don't care. They don't care who owns the hospital, as long as they trust the doctor who puts them there. I suppose it's possible that my patients are all Methodist, Episcopalians and Lutherans and they didn't want the Baptists and the Catholics to get the money in the first place, but they don't really care.

They are asked to sign a financial disclosure statement when they come in that simply tells them that these doctors listed have a financial interest in the hospital, and if they have a problem with that, call administration, and I don't know, has the phone ever rung about that? They don't care, as long as they think they're getting good care.

MS. MATHIAS: Okay, great. John?

MR. BATES: I'll make several quick comments. One is that I don't think there's that much data out there in the sense of medical outcomes so that you can

say my chance of a complication going into hospital A versus hospital B is different. I don't think there's enough of that out there for people to go by.

I think they rely very heavily on the reputation of the hospital or on the opinion of somebody they respect. So, if they're next door to a nurse who works at Baptist and they say Baptist is a great hospital, you ought to go there for your hernia, that will help sway them in their decision, at least that's our experience.

I think it's also very hard for the general public to differentiate between what we would call service quality. That is to say are the beds neatly made, is the lunch line clean, and all that sort of thing, versus the medical outcomes, like did they get the right operation, did they get it timely, did they like the medicines? So, I think it's difficult for them to differentiate, and they often jumble them up.

All that being said, though, we do find more and more people are calling up ahead of time and saying, what is your complication rate on this, or what are your outcomes on that, particularly high-risk elective procedures. We get a lot of calls like that, for example, on heart surgery for children, because families who need that work done, particularly if it's

a high risk situation, they will call eight or 10 different centers and try to get an opinion, because it's a once-in-a-lifetime shot and they want to get it right.

So, I think it's increasing, but I think in the long run it's going to be very difficult. I always ask our board, well, how would you analyze this equation? It will cost you $5,000 more when you go to your coronary artery bypass at hospital A versus hospital B, but your complication risk will drop by a half a percent.

MS. MATHIAS: A difficult evaluation. John?

MR. WILSON: Outcomes have sort of been in the eye of the beholder in terms of getting the information and how they're interpreting the information. Unfortunately, the outcomes are usually interpreted by those individuals who collect it and the hospitals that are involved. So, you would have to say that they're going to show their best face with these.

And with physicians, I don't know really how in the world, particularly with HIPAA, that we're going to get valid outcomes if we can't share data.

MS. MATHIAS: How -- we've heard how the consumer patient makes a decision for, you know, the hospital. Sometimes it's word of mouth and friends and

quality information and things like that. Is that the same for the physicians in Little Rock?

MR. WILSON: Well, you know, if you have a choice. If you're tied into a particular system of some sort, HMO or PPO, then you don't really have a choice sometimes. So, but I think word of mouth is generally the way it's gone. And I'm going to -- I have to ask to be excused, I have an obligation in Little Rock, and a plane to catch. So, I ask your forgiveness for leaving early.

MS. MATHIAS: Well, thank you for your time to come, and I look forward to talking with you in the future, but take care. And I think Joe had to leave as well. That's what happens when we're lucky enough to get people who travel here, we have to face their schedules as well. I think Jim had a response on that.

MR. KANE: Just a quick comment about how the physician, or at least how I recommend which hospital a patient go to. The first and most important question when I recommend hospitalization for a patient is, I ask them if their insurance directs them to any particular hospital. And I tell them uncertainly that they have to go where they get the best deal. Secondly, I ask them if they have any preference. I tell them that I go to the Heart Hospital, I go to St.

Vincent's, we have doctors that go to Baptist Hospital if they want to go there. And even if they say, well, Doctor, why don't you tell me where I would be best treated or happiest, and then I make my recommendation on the basis of that, but I give them -- always give them the option and always check on where they can get the best deal with their insurance.

MS. MATHIAS: Okay.

MR. ELIASBERG: Kevin, actually, this question sort of keyed off something on your slides, and I'll ask you -- I'll ask you this instead of Bob Shoptaw.

MR. SHOPTAW: Thank you, Ed.

MR. ELIASBERG: You might be less grateful when you hear the question, though.

Your slides indicated that at one time there were five HMOs in the market, and then two left, and they were listed as, if I remember correctly, Aetna -- Prudential, excuse me, and HealthSouth.

MS. MATHIAS: Cigna.

MR. ELIASBERG: Health Source, excuse me, were the ones that left.

MR. RYAN: That left the market? Yeah, not in light of the recent headlines. Suffice it to say, there are fewer HMOs today than there were prior.

MR. ELIASBERG: There were two major HMOs that

left.

MR. KANE: United is still there.

MR. ELIASBERG: Right. Yes, but two left.

MR. RYAN: Three, United, Prudential and Health Advantage.

MR. ELIASBERG: I thought the need -- give me just one second -- I thought there was two that left.

MR. RYAN: Cigna and Prudential are no longer really in the marketplace.

MR. ELIASBERG: Right.

MR. RYAN: In HMOs -- they are still there in PPOs.

MR. ELIASBERG: When you were doing your work-up for your study, what was your understanding of why they left?

MR. RYAN: I mean, that is a good question. And I think you can even apply the answer more broadly to other than HMOs, health insurance companies in general. For example, there have been about 40 health insurance companies that have exited the Arkansas marketplace over the last few years. As you saw, I believe it was Bob's slide, there was -- there are still a number in the state.

When we've talked to carriers, and talked to the brokers who have dealt with carriers over the

years, answers vary. For some carriers, either HMOs or PPOs, they've left the marketplace because they never really had a sufficient penetration, and did not want to spend resources to try to attain a larger penetration. HMOs, managed care in general, has not really taken off in Arkansas. Arkansas is a largely rural state. We only have one true urban center in central Arkansas, and in Little Rock and north Little Rock. We have only a few smaller but still urban centers in the state.

For managed care and HMOs to really be successful for multiple, multiple carriers, you have to have a pretty condensed population, and Arkansas doesn't have that.

As I said, we're a rural state with networks that are fairly diverse. So, I think that's probably another reason. It's -- I think it would be really difficult for a large number of carriers to have a presence in the state, just in terms of the demographic make-up.

MR. ELIASBERG: I don't want to cut Mr. Harrington off, but just one follow-up question on that. So, if we see rates going up like Mr. Meyer talked about, about them going up, notwithstanding that, you would be surprised if we suddenly saw the

advent of new HMOs coming into the state from people other than from providers already -- from plans already in the state? Or would you?

MR. RYAN: I'm not sure I understand the question.

MR. ELIASBERG: Okay, rates seem to be going up, that is to say HMOs are getting paid more of --

MR. RYAN: I'm not sure I agree with that, but.

MR. ELIASBERG: Well, okay, some people --

MR. RYAN: Because I think you've hit on a real important issue. You know, premiums are definitely going up, I think the data clearly indicates that.

MR. ELIASBERG: Yes.

MR. RYAN: But I'm not sure that you can assume, and I don't have the numbers, to assume that profits are going up. Because I think carriers are operating under obviously the same types of conditions that health care providers and other folks, and I'm obviously not the most qualified to speak for carriers, but in my conversations with them, you know, they're having the same type of cost containment issues that really all members of the health care industry are.

And so, you know, I'm not sure one implies the other.

MR. ELIASBERG: Okay, fair enough, and I'll

stop and let Mr. Harrington get a word in on this.

MR. HARRINGTON: I would agree with what Kevin just said and add one other factor. There are companies who have come to the state with the intent of providing a product, and then they do their feasibility study and they find out we are a very unhealthy population. And they really don't want to deal with that.

So, I'm proud that there are some that have managed to stay there and have been willing to stay there and work with providers to deal with the unhealthy population that we have. Others aren't even willing to touch it.

MS. MATHIAS: John?

MR. BATES: It was interesting, I got hired to come to Arkansas from California because I had managed care experience there and they were getting ready for the storm to hit Arkansas that just never came. And the wonderful story about it, which I think in answer to your question to Kevin, will they come back? I think the answer is no, and the story goes like this: When the HMO salesman calls on a doctor in rural Arkansas and rings his doorbell and says, I can bring you 20 percent more business if you give me a discount on your prices. And his answer is, A, I don't have

anybody to do the work, B, I haven't had a vacation in seven years, and C, get out of here.

And so, you need to have excess capacity in order for competition to get going with managed care, and we just simply don't have enough of that in most of the state to support that.

MR. ELIASBERG: Just one follow-up question on that, if I might, Jonathan. What about Little Rock itself?

MR. BATES: I think in certain market sections, there is enough excess capacity to see it. I think cardiology is one of them, adult cardiology. I think adult orthopedics may be another one.

MR. ELIASBERG: Okay.

MS. MATHIAS: I want to say two things real quick. First, St. Vincent's is not here today to respond, and we do allow all written comments to be submitted, and if they feel the need to address what Dr. Kane said, they are more than welcome to send a written comment, but that's totally up to them.

Second, we had a session yesterday where we were looking at horizontal networks and vertical arrangements, and granted they were all academics and economists, so they weren't in the trenches like we have here on this panel. The feeling that those

situations or those relationships were not working for the most part, a lot of the integration and a lot of the hospitals who also offered nursing care home and physical therapy had not made efficient use of their services.

It seems like that may not be true at least for Baptist in Little Rock, or in Arkansas, for that matter. I was just wondering, in raising the question about the efficiencies found with doing those kind of arrangements, and then if anybody had a response to maybe the detractions from them. So, I throw that out maybe to Russ first and then see if anybody wants to add to.

MR. HARRINGTON: We believe in the consolidation of our efforts in terms of our own system, and without a doubt, we have impacted efficiencies throughout our system. That's been true in partnershipping with a number of physicians and rural health centers, federally-funded community health centers. And we've always found when we work together, we can become more efficient. So, I think -- I think there's a way to do that, based on the experience that we have, and almost every physician who joins our Arkansas health group finds that we can bring efficiencies to the operation of their practice.

So, we've been very successful at doing that, as well as the 13 physical therapy clinics that we have out in the communities across the state. We not only can bring efficiencies to that service, but we also make them much more accessible when they're in the community of the people that they serve.

The other thing that I would like to touch on, if I might, because of all the things that I've heard, especially about the BlueCross/Baptist relationship as a relationship that we're very pleased and proud of.

Twenty-five percent of our business comes through that network. So, it's not like it's everything that's done. And in fact, we have 21 other contracts with other provider -- other managed care or insurance cooperatives or whatever. It is true that we only work with one HMO, but we own half of them. We've always thought it would be poor business to contract with a competitor of our own HMO, but the impression, I think, has been left that BlueCross has all the business in the state and that Baptist doesn't have any, except what BlueCross brings us, and we're proud of that relationship. But again, it's 25 percent of our business, and in addition to them, we have 21 other contracts.

MS. MATHIAS: Jim?

MR. KANE: Just to comment about these ancillary services and how they're handled at the Heart Hospital, being that small, we don't really have the ability to do all of those. We contract those out. And for example, for rehabilitation, we would like to use Baptist rehab, they're the best, absolutely the best in the state. For cardiac rehab, we use one at St. Vincent's. A lot of our patients are from far away in the state and they can't get to a central area, so that we wind up using the local areas like Mr. Harrington has alluded to.

One apology to Mr. Harrington, he says I showed him owning more hospitals than he actually does.

MR. HARRINGTON: Giving more credit than I should have.

MR. KANE: Not only that, he didn't want those hospitals.

(Laughter.)

MR. KANE: That was my fault.

MR. ELIASBERG: Mr. Harrington, this next question is probably best for you, and first of all, I've got to tell you, there's a caveat here. I'm the only person up here who is neither from nor has never lived in Little Rock, okay? So you've got to cut me some slack here on this one.

MR. HARRINGTON: We can change that for you.

MS. MATHIAS: It's a very welcoming place.

MR. ELIASBERG: I'm sure, I'm sure. What I would like to get at is this: We've heard discussions and seen things in the trade press about the development of situations where hospitals in outlying regions have suddenly become competitive forces with respect to hospitals located in urban centers, particularly with things like cardiac -- cardiology programs and orthopedic programs and things like that.

I was wondering what, if any, sort of activity like that there is in the Little Rock area.

MR. HARRINGTON: Sure. It's primarily just on the outskirts of the metropolitan area, in places like Conway and Benton and Searcy, but it is across the state when technology continues to develop, and the price comes down on it, those hospitals get some of the technology that many of us in central Arkansas have had exclusively. And when they do, that oftentimes reduces the number of patients who migrate out of that community and come into us.

In fact, we've probably felt that in the area of hearts more than we felt the heart hospital. Because it seems like every hospital in the state out there has a grand design to have open heart surgery.

And when they do, like two programs in Searcy, and a new program in Conway, and you just keep looking out in the state there's more and more. It does have an impact on us, certainly, there's no question it does.

MR. ELIASBERG: And here's where the question from the boy from Florida here is, Conway is about how far from Little Rock?

MR. HARRINGTON: Conway is about a 55-mile drive.

MR. ELIASBERG: And you mentioned that you're getting less people coming in from around that area, they're going to Conway. Have you seen any outflow from the Little Rock or from Little Rock suburbs going outward?

MR. HARRINGTON: No, no, we have not seen that. I don't think we'll see that. And Conway is probably not that far. Arkadelphia is 55 minutes, Conway is probably 30 minutes.

MR. ELIASBERG: Okay.

MS. MATHIAS: I think Bob was next and then John.

MR. SHOPTAW: Ed, on that point, I think it's interesting that hospitals that Russ just described are in our HMO and PPO network. In other words, these collateral hospitals in and around the metropolitan

area all have the opportunity for patient flow and patient volume, just like Baptist. So, in Conway, you can go to Conway hospital and receive the same HMO or PPO in network benefits that you can at Baptist and Little Rock, the same thing in Benton, the same thing in Searcy, the same thing in Jacksonville for that matter.

Association you would understand that the relationship we have, all of the HMO volume in central Arkansas doesn't automatically have to go to Baptist. These other community hospitals participate on a full parody basis.

MS. MATHIAS: Actually, I had -- I'm sorry, Jonathan.

MR. BATES: I would like to kind of take your question a little bit further and link a couple of pieces together here. We talk about the moving window, that's if you're sitting in a train and you're going along in the countryside, do things come into view in the front of the window and things disappear out of the left-hand side of the window, as you're going along, and we see our repertoire of care like that, work that is now taking place in ambulatory settings or private offices or even in homes, used to be the basis for hospitalization. Twenty years ago, we had many

children with hemophilia in the hospital. That is not an inpatient disease anymore, it's an outpatient disease.

So, what happens is things are constantly dropping off of the list and constantly being added. So, what happens is how do you strike your balance? How do you maintain that? Because the size of that window basically talks about the size of your enterprise and what you can do.

So, new technology and new techniques and new physicians and new things like that add to the front end of your window, but they're dropping off the back end. And our posture is that the communities are going to become capable to do that. Neonatology is one of those areas you wouldn't have to go back very far to find a time when the only neonatal care to speak of was in Little Rock. Now there are strong neonatal ICUs all around the state and they are doing an excellent job as they develop that capability. And in time, they will add to that and add to that and add to that.

So, that window will continue to have things migrate out to community hospitals, doctors' offices and so on. So, there is auto dynamic there to link what you add as well as what you subtract.

MS. MATHIAS: Just a quick question for Bob so

that we have a little bit more background information about Little Rock, and then actually I think it's about time that we start to wrap up. So, I am going to allow everybody to have about 90 seconds of closing comments, and I will pretty much -- okay, Commissioner Anthony will ask her question next and then we will have the closing comments, but just so I'm aware, the number of covered lives in Little Rock, I don't think I saw that on the slide. If I did, I apologize, but approximately what is the number of covered lives and what is the -- how does it break down between the various insurance companies in Little Rock?

MR. SHOPTAW: Well, I can speak, I think, to the total insured population, I can't really speak to some of our competitors because they're obviously either state-wide or they don't report their numbers in a four-county focus, obviously.

In terms of our programs, we have 133,000 people that are covered in the four counties in central Arkansas. That would be probably in terms of the total insured mark, and I'm talking about all public and private patients, who would be somewhere around a 28 to 30 percent market share.

Now, if you begin to break it out and just look at the insured market, obviously that's what's reported

at the insurance department, that's like 1.8 billion dollars state-wide, and you can do the math on it, and it looks like we've got a 50 percent market share.

The issue is, though, that 45 to 50 percent of the market is actually self-funded and so forth and you've got to add that in and all of a sudden it becomes essentially, you know, a $3 - $3.5 billion insurance pool for the under age 65 population.

So, there's a lot of gradations along those lines, but remember that we're operating basically on a scale economy proposition. Let me just give you some numbers in terms of administration costs in the Little Rock market for the HMOs. Our costs, our admin cost as a percentage of premium for the first nine months in 2002, which is most recent reporting period, was 8.6 percent.

QualChoice and United, the other two competitors, are double that. Now, you want to know why we have market share. When you look at the fact that you've got that kind of spread in terms of the administrative cost to the risk management fees, that the competition is taken off the table, when you translate that into rates, then oftentimes we have the lowest price.

And quite frankly, we don't apologize for that,

because it basically is being passed on to the customer.

The other thing that I would like to say, is if you look at all of our programs and go back 10 years, and of course the health insurance industry is really a cyclical business where you have two or three years of gains and two or three years of losses, that sort of thing. We, in terms of our private programs, would have an accumulation of about 6.3 billion dollars over the last 10 years. The amount of money that we put in reserves, which we are owned by our policyholders, being a not-for-profit mutual, was 117 million dollars over that 10 years.

That's 1.9 percent profit margin, if you want to use a cyclical term. Out of that 1.9 percent, half of it came from investment income, the other half came from basically the margin of taking in premium and then taking out admin costs, and whatever the net is, is what we call an operating margin.

So, back up to the point I think that Kevin made earlier, at least in our situation, there's not any gross profit margins that are being made off of the volume. And to the extent that we talk about health care costs going up, and we want to talk about insurance premiums. Insurance premiums reflect what

you've heard here today, and that is the rising cost of technology, personal service expense, the issues around medical malpractice insurance, and the increased utilization, much of which is demand driven by patients themselves.

Of course as an industry, what we're doing is we're all beginning to look at really consumer directed health care where you've got $1,000 or $2,000 that the patient decides to spend on their own and then a comprehensive major medical on top of that and that's the reason why you're actually seeing a decline in the percentage of the population that are in HMOs in our state.

The HMO population is as a percentage has actually gone down in the last three years. And that's happening across the country as well.

MS. MATHIAS: Commissioner Anthony, you had a question?

COMMISSIONER ANTHONY: Yes. (No microphone used, inaudible.)

MS. MATHIAS: For those of you who couldn't hear the question, I believe it was how many full-service hospitals are there in Little Rock, and regarding St. Vincent's, if it was an effective competitor five years ago, is it an effective

competitor today, and if not, why not? Is that about it?

MR. RYAN: I think on this I'll defer to my colleagues, both in terms of the number, but especially in terms of an evaluation of St. Vincent's. My sign was turned, I was actually going to speak to one of Sara's earlier questions about the number of covered lives in central Arkansas.

MS. MATHIAS: I'm sorry.

MR. RYAN: Little Rock and central Arkansas actually has a lower rate of uninsurance, if you will, Little Rock and then the northwest corner of the state. It's, as we spoke earlier, much higher in the rural areas.

And if there's somewhere between 200 and 250,000 citizens in the central part of the state, the covered rate is probably around 90 percent. Now, that's all programs, government, private, et cetera. It gets much higher in -- for example, rural north central section of the state. It's somewhere in double digits.

In terms of quality of care and full-service providers, I think I'll defer to my panel mates on that.

MR. KANE: I'll be glad to comment, since I go

to St. Vincent's every day. What happened to St. Vincent's was basically when the sisters sort of got old and retired, that very nice feel that was there deteriorated and the -- frankly, and they're aware of this, too, the quality of care just declined dramatically. And then as other institutions hired away some of the best nurses, there were not the good nurses left there.

Now, as I say, they are fully aware of this, and recently they have begun to pull up, and one of the reasons that they have begun to do that is simply because of competition, and the Heart Hospital has raised the bar for the level of competition, as well as the quality of care, so that, for example, Baptist is doing some of the same things, they're forced to get new cath labs, they're refurbishing their wards to make them look new instead of old, and sort of worn out, and they are trying very hard to re-establish their image.

Part of the problem is their location. The city has moved westward beyond them. They just have flat moved beyond them. And that's one of the reasons why Baptist where they are, years ago, Russ or whoever saw that as an important issue, and then when we built the Heart Hospital, we were a few feet down from Baptist, actually.

MR. HARRINGTON: Back doors, yes.

MR. KANE: He sees it every day from his office, he just can't stand it hardly.

MS. MATHIAS: John, I think you had a response as well.

MR. BATES: Somebody can help me count here, but I mean, it's the University Hospital, Baptist Hospital, St. Vincent's, you want to count southwest on our list, do you want to count North Little Rock for you on the list, Rebsman, how far out do we want to go? Something like that.

MR. HARRINGTON: There are three major institutions and four community hospitals in the central Arkansas area.

MR. BATES: That's a good way to think about it.

MR. RYAN: You could perhaps make a case for Conway and Benton, you know, depending on how far out.

COMMISSIONER ANTHONY: Their primary market is what?

MR. HARRINGTON: We say our primary market is six counties, and our secondary market is 13 counties that surround us, and then the tertiary, the third level is the state of Arkansas. There's mainly the six counties of central Arkansas that we focus on in the

market.

MR. BATES: As for the declining quality, I would just offer something I heard a long time, it's that when things go well, it's because you have outstanding physicians and nurses, and when they go badly, it's because of poor administration.

(Laughter.)

MS. MATHIAS: That's a self-reflection there. We are getting closer to the time, so now I am going to give everybody 30 seconds to do their final wrap-up and I will keep you pretty close to time, and to flip sides, we'll start with Bob this time and work our way down.

MR. SHOPTAW: Well, Sarah and Ed, thanks very much for the opportunity to participate. I really think Little Rock is a very good representative market to look at in terms of the dynamics that are going on. I think we're large enough that you are seeing what's occurring as far as national trends. I think we're also small enough that you can really put things under a microscope and luckily we have got individuals like Kevin and others in the community that, you know, in an objective fashion can really pull that kind of data together. And Kevin, I think you would agree that we have tried to make our databases and so forth available

to you and your colleagues and we'll continue to do that.

MS. MATHIAS: Thank you, Bob. Jim?

MR. KANE: Just really a question, if there was a hospital where you could go that had healthy doctors, happy nurses taking care of satisfied patients with a shorter stay, a better outcome, and a lower cost in some cases, why wouldn't you want to go there, why wouldn't your employer want you to go there and why wouldn't your insurance company want you to go there? Thank you.

MS. MATHIAS: Okay. Russ?

MR. HARRINGTON: I would just say there's no lack of competition in the Little Rock metropolitan area. We have challenges that face us every day, increasingly, and our focus has always been not on the competitors but on our own institution. We've got to do what we do best, and find ways to improve it, and study what the community needs and try to meet their needs, and if we do that, we don't have to worry about the others.

MS. MATHIAS: Thank you. John?

MR. BATES: I think in our state where we don't have such a huge set of resources, financially and otherwise, to do things, competition turns out to be a

luxury, and coordination and collaboration and cooperation turn out to be our weapons.

MS. MATHIAS: Kevin?

MR. RYAN: Thirty seconds or less, there is no fat left in the system. In health care providers, in health insurance carriers, and the health care system, I don't think there's any fat left to cut. I think Little Rock has -- one of the finest health care systems in the world. Perhaps I'm hopeful, but I can unequivocally say that across the board.

Bob alluded to this, evidence and data is key to making improvements in the system. His folks have shared their information with us, other health care providers in other parts of the system have shared and it's made the difference in making policy decisions to help improve that system. Hence, the need for cooperation.

Finally, this issue is a hot button issue. The issue of the uninsured, cost in the health care system and competition. Our surveys around the state show time and again, everyone we spoke to, this is on their radar screen, and they are looking for answers.

MS. MATHIAS: Thank you. Just a couple of quick wrap-up. We will reconvene at 1:30 this afternoon. We will be looking at post-merger conduct.

I think that will be a very interesting session that we'll have this afternoon. We will pick up the conference call again at that time.

Also, I'm getting tired of saying this, but it's kind of like a camp site in here. If you brought something in, if you would take it out with you, it makes my job a little easier and I always appreciate that. And I wanted to give a resounding round of applause to our panel who took the time and effort and I think it was an outstanding product that we were able to see today and learn from. So, a round of applause.

(Applause.)

MR. WIEGAND: Good afternoon. We would like to first check the microphones, are they working?

I think this one is working. Good afternoon, we would like to welcome everyone to this afternoon's session. Our topic this afternoon is hospitals' post-merger conduct. I would like to briefly introduce the panelists we have in the order in which they're going to be presenting initially, and then at the end of the afternoon, we will have a discussion period.

The speakers are seated in the order that they're going to present their materials, starting with Lawrence Wu of NERA, and then we have Bill Kopit at Epstein, Becker and Green, Robert Taylor with Robert

Taylor Associates, Kirby Smith of Susquehanna Health System, Jamie Hopping from Arden Health System, Jim Langenfeld from LECG, David Balto from White and Case, and then Seth Sacher from Charles River Associates, and David Argue from Economists, Inc.

We'll move right into things by asking Lawrence Wu to kick things off.

We're going to take a break along about 3:00, and I should have also introduced the co-moderator for this afternoon's session, Rich Martin from the Department of Justice.

MR. WU: Well, thank you for inviting me to speak. I appreciate the opportunity to do so.

One of the key initiatives announced by the FTC last year was the agency's interest in looking at the conduct and performance of hospitals that recently completed a merger or acquisition. This is an important initiative, because post-merger reviews, if they can be done well, and if we have the patience to let the market sort things out, less sense the pressure to forecast the future, which is probably helpful in a complicated industry in times of change.

This approach to merger analysis to me makes sense because it is premised in the belief that in the first instance the market works. The analysis of

post-merger hospital conduct is a serious undertaking, but I would like to borrow from David Letterman to help me introduce the 10 subjects that I would like to talk about today.

So, ladies and gentlemen, here they are: A top 10 list of the phrases that are most likely to elicit concerns among hospitals and their antitrust counsel: Number 10: Hi, we're calling because we're doing a post-merger review. Number 9: Your friends at Managed Care Plan, Incorporated told us how to find you; Number 8: You're not the target, but can you send us your data and documents? Number 7: You are the target, payors tell us that contrary negotiations are more contentious. Number 6: Area health plans tell us that reimbursement rates rose after the merger. Number 5: Why can't prices be as low as they were before the merger? Number 4: Can you substantiate the efficiencies and quality of care improvements that were discussed in your pre-merger planning documents? Number 3: Guess what? We found out the merger actually lowered your costs. Number 2: And we found out that your prices are really higher than the prices at comparable hospitals. And Number 1: Let's talk about remedies.

Now, there are serious questions and issues

behind these 10 phrases, and today I would like to give you an economist's perspective on these issues. And I hope my comments will help the public and hospitals around the country understand why the FTC is interested in these issues. And I also hope that my comments will aid the investigative process.

So, let's begin with issue number 10. The pros and cons of post-merger reviews. The FTC's review of already consummated hospital mergers is an important part of the health care antitrust program, and I applaud that initiative. In an industry where the vast majority of mergers have the potential to generate efficiencies, an environment where insurers have had bargaining strength, and a marketplace that is dynamic and evolving, it is in general good competition policy to let the market sort things out first.

Moreover, questions had been raised about the predictive value of the tools that are relied upon in the pre-merger review process. And these include tests for geographic market definition, which rely on patient origin and destination data, and critical loss computations.

Do the results of these analyses inform us about the dynamics of the marketplace and the competitive responses of insurers to changes in price?

Focusing on the competitive effects of the transaction after the fact, a post-merger review can resolve some of the uncertainties that surround the need to forecast the future.

However, the analysis of post-merger pricing and conduct rose as new uncertainties, and it has its blemishes. After all, there is no free lunch. A post-merger review is useful in that it does focus our attention on the competitive effects. However, we do have a new set of problems to deal with. And these include the difficulty of measuring the actual change in price, measuring possible improvements in quality of care, separating merger effects from other things going on in a market since the merger, and finding and constructing relevant benchmarks.

In addition, if hospitals tend to integrate their assets quickly after a merger, it may be difficult to unscramble the eggs, and if the agencies find that post-merger remedies cannot be relied upon to resolve post-merger anti-competitive problems, the agencies may have no choice but to revert to pre-merger reviews as their only tool of enforcement.

And while I'm optimistic that a retrospective can be done well, there are a number of difficult and burdensome problems that can affect how well a review

is done, and the conclusions that are warranted in doing the analysis. And I'll touch on some of those issues next.

Issue number 9: Evaluating the views of health plans. The views of health plans matter. They always have and they always will. After all, they do play an important role in the marketplace. They stay informed, they work on behalf of individuals and employers who negotiate prices, and they have varying degrees of bargaining strength, or at least they used to.

For a post-merger review, the complication is that all managed care plans view price increases as being problematic, whether they are justified by higher costs or not. And in a world where hospitals have seen an increase in their bargaining strength, it is difficult to separate increases in price due to merger enhanced market power from increases in price due to external changes in the marketplace.

During a post-merger review, it is important to do this, because in the end, much of the analysis will be about causality. If, in fact, prices rose, was it due to the merger, or was it due to something else?

In addition to causality, much of the analysis will focus on identifying and quantifying whether the merger has had a systematic anti-competitive effect.

In light of the heterogeneity among health plans in terms of their products, enrollment and negotiating ability, this is especially important. And that is because prices are likely to vary widely across payors. Some may have seen their prices rise after the merger, some may have seen their prices fall.

So, it isn't sufficient to rely on the views of just a handful of health plans. We need the views of more. The views of area health plans are important and we should consider their views, but it is also important that we test these views empirically to see whether the concerns, if there are any, reflect a systematic anti-competitive problem that be attributed to the transaction.

Issue number 8: Third party discovery. To learn that one is not the target of an FTC investigation is obviously a reason to breathe a sigh of relief, but for third parties there is a burden to produce data and documents that could be costly and time consuming. And I don't mean to understate the costs of complying with a subpoena or a CID, but I do want to emphasize the important role that third parties, especially third party hospitals, can play.

First, the documents and data of third party hospitals are important for evaluating the credibility

and strength of all of the sources of competition that face the merged entity. Second, the information is likely to be crucial for purposes of finding and constructing a competitive benchmark. And third, it is the combination of data from third party hospitals and health plans that can help make it possible to disentangle the effects of the merger from other compounding factors, such as the bargaining strengths of individual payors, trends in the marketplace, and reactions and responses of rivals.

When getting information from a third party hospital, I would be sure to get information on not only prices over time, but also the hospital's competitive responses, excess capacity, expansion in services, case mix changes, changes in various contract provisions, and bargaining position. It is information from third party hospitals that can help to identify marketplace trends and developments, and to determine whether rivals have the ability to keep prices competitive.

Issue number 7: Contentious contract negotiations. Isn't this just competition at work? From the trade press, it seems that negotiations between hospitals and providers had become more contentious all around the country, merger or no

merger, and it seems that the views are widely held by both health plans and hospitals.

From an economist's point of view, it's hard to know what to make of this, without more information, and that is because reimbursement rates are the product of a bargaining process. And it is hard to distinguish competitive tussle from anti-competitive muscle. But in the end, I would suggest that you focus on two sets of questions: The first set has to do with the outcome of the negotiations; did prices rise, and what were the terms of the agreement? The second set of questions resemble the kinds of questions that are usually asked during a pre-merger review, but they ought to be asked again. Is there any evidence that the negotiations are more contentious because of the acquisition and the elimination of a competitor from the marketplace?

It is important to isolate this particular cause, because in a post-merger review, this is the underlying theory of anti-competitive harm. While this may not be easy, because more contentious contract negotiations could be due to a number of factors, such as the general shift in bargaining power from health plans to hospitals, but we must be clear in developing the hypotheses that we want to test, and this means that we should be clear about the nature of competition

that was lost as a result of the merger.

But in the end, as with pre-merger reviews, there must be a clear articulation of the theory of anti-competitive harm.

Issue number 6: Estimating the post-merger change in price. You know, life would be easy if all we needed to do was to compare the average reimbursement rates before the merger and after the merger. But as you might suspect, once you have economists involved, an empirical study of actual prices paid, which is not the same as gross charges or the list prices that are on the charge master, it is not that simple.

There are a number of factors that enter into such an empirical study, but the one I want to focus on today is how one might measure whether there has been, in fact, an increase in price due to a merger. While this is an empirical problem that probably requires the application of econometric methods, and econometrics is the right technique, because it is a tool that is helpful in quantifying the price increase, if any, that is attributable to a merger, and not accounted for by other shifts in market supply and demand.

One of the negative difficulties with an econometric analysis is that it is often hard to

control for changes over time and differences across hospitals. For example, measuring and tracking changes in case mix remains an issue that is just as difficult in a post-merger review as it is in a pre-merger review. In a pre-merger review, the ability to track patient case mix has been an issue when interpreting patient travel patterns. In a post-merger review, what also must account for the case mix, because case mix is one of the most important determinants of price.

There are two approaches that I think we can take here. One approach is to include patient case mix as a variable in an econometric model that explains price movements over time, and this approach attempts to directly capture the effect of changes in case mix on prices. An alternative is to simulate the prices that would have been paid for the services provided to some fixed population of patients under different contracts.

To connect this analysis, one would begin with a population of patients treated at one or both of the merging hospitals before the merger, and enough information about each patient's diagnoses and treatment received, and with the contracts of the merging hospitals in succeeding years, including the period after the transaction. You would then apply the

reimbursement terms in those contracts to this same cohort of patients to track the changes in prices over time for this same set of patients.

By simulating revenues that the hospital would have received for the same set of patients, we are then able to compare the hospital's case mix-adjusted price, which would correspond to the revenues received for the treatment of some standardized set of patients. Once we have the case mix adjusted price, we can then perform an econometric analysis to account for the influence of other factors in the marketplace, such as rising costs, health plan's specific factors, terms of the contract, and other factors that might have affected market supply and demand. The pricing study is only as good as the data used for the analysis, so great care must be taken to construct a data set of case mix-adjusted prices over time.

Issue number 5: Are pre-merger prices useful as a competitive benchmark? A concern about rising prices is typically translated into the following desire: Why can't prices be as low as they used to be; that is, at pre-merger levels? Put differently, can't we use pre-merger prices as a benchmark against which we evaluate post-merger pricing? In some industries, this might be appropriate, but in industries such as

health care, I think this is especially inappropriate, and there are three issues that I want to briefly mention.

First, the cost of providing hospital care has been rising over time. And by cost, I mean expenses such as medical supplies, pharmaceuticals and nursing costs. And in competitive markets, an increase in market-wide costs will normally lead to an increase in price.

Second, in the past few years, there clearly has been a shift in bargaining power from health plans to hospitals, and this is the result of a variety of influences, as we've heard, in hearings during the past few weeks. This includes consumers' desire to have the freedom to go into the hospital of their choice, buyer preferences for broad provider networks, and a reduction in hospital capacity.

This reversal in negotiating positions which by itself is nice, as far as anticompetitive harm, can lead to higher prices, even in competitive markets.

And third, prior to the merger, hospital reimbursement rates may have been below long-running competitive levels in some markets and this could be the case, for instance, in markets that have been under rate regulation for many years. For example, in New

York, where I live, prices have generally increased after the deregulation of rates in 1997 as the forces of supply and demand began to take hold.

So, in an evolving marketplace, post-merger prices are too often unlikely to serve as reliable benchmarks for the competitive price -- competitive prices that are attracted because they're observable -- that is not good enough. The competitive benchmark is not likely to be a price that we have observed in the past, an estimate that we must construct, based on a clear specification of the marketplace, had the merger not taken place.

Issue number 4: Efficiencies and improvements in quality. What most, if not all, transactions are motivated by is the desire to improve the quality of care or to expand the range of services that are provided, but when they are merger-specific, they ought to be counted among the pro-competitive benefits of the transaction. In the competitive markets, improvements in quality are typically associated with an increase in price.

But how much of an increase in price is justified by the improvement is an empirical issue dependent on factors such as the cost of making the improvement, as well as the buyer's demand for the

improvement.

There is no question that it is difficult to quantify improvements in the quality of care or access to care, but we should continue to do our best to evaluate efficiencies, and do it the way that we always have been doing it, estimating the variable cost savings, the savings that are likely to be passed on to buyers, and the degree to which the efficiencies are merger-specific.

And we might be able to use the tried and true technique that economists apply when studying markets where the end product is not easily quantified or measured, but it is difficult to measure output, one tends to measure inputs. And this may not be a bad way to go, because there typically is information on investments already made in medical equipment, construction, and the additional new service offerings.

If the clinical and quality of care benefits will continue to be largely subjective, does that mean that we should abandon all efforts to study prices and costs over time? I don't think so. To me, what it means is that an econometric analysis is likely to produce an overestimate or the upper band of the merger-induced price increase.

But even so, the study, I think, is still

worthwhile to do, because if we find no merger-induced price increase, then we can end our inquiry, where if we find a positive price increase, we should recognize the bias and proceed with more work.

Issue number 3: Reductions in costs. As with improvements in quality, most, if not all mergers, also are motivated by the desire to reduce costs. While lower costs can increase the profit margin for the merged entity, lower costs also help consumers. In general, a firm's optimal price tends to fall where its costs fall, whether that firm is a monopolist or one among many in a competitive marketplace. And health care markets are no different.

However, as you might suspect, it's not always easy to observe the degree to which cost savings are passed on to health plans, and one complication is that the merger-specific cost savings may not be across the board. While cost savings are achieved in one area, costs may have increased in other areas.

A second complication is that there is likely to be a lag between the period in which the cost savings were achieved and the period in which the prices are reduced. And that is because most contracts are negotiated well in advance of the actual effective date of the contract, so in other words, the realized

cost savings would not have been known at the time the contract was negotiated. And a third complication is that prices depend not only on past and current costs, they also are likely to depend on expectations of future costs. And this is especially true for longer-term contracts.

So, even if a hospital has been successful in reducing many of its operating costs following a merger, if forecasts of rising labor costs, for example, could be enough so that would weaken the link between cost and price.

So, while it may seem obvious that a reduction in cost ought to lead to a reduction in price, the analysis is rarely that simple.

Issue number 2: Comparing prices over time and across hospitals. The detailed information on the contracts and revenues of comparable hospitals, the pricing analysis also could be done to compare prices over time and across comparables, and this analysis combines the benefits of both time series analysis and the benefits of a cross section analysis. The disadvantage is that the data requirements are typically quite large.

And whether this can be done well depends largely on the availability of reliable and relevant

data, and especially data that captures differences in quality of care, available services, and access to care across hospitals. And it may not be easy to get these data, especially from third parties. And whether the results are reliable and can withstand scrutiny will depend on our ability to account for shifts in supply and demand, expectations about costs, and other factors that are likely to matter while constructing the price that would have been observed had the merger not taken place.

And finally, issue number 1: Remedies. If a significant and systematic merger-induced price increase has been found, is there a way to return the marketplace to competitive conditions? Divestiture is one solution, although there are a number of practical issues that make this a difficult solution to implement.

Assuming that such a solution is feasible, I would like to talk about all the implications of such a solution on hospitals' incentives, especially in the short run. In the short run, if divestiture is the only practical remedy, it is unlikely that during the course of the retrospective investigation, that the merging hospitals will continue to invest heavily in new medical equipment and construction, or to add new

services.

So, just talk about a divestiture could lead to delays or cancellation of ongoing efforts to expand capacity or to invest in infrastructure. And this is a social cost of the post-merger review process.

While the interested agencies must do their job, I mention it because it ought to be a consideration for acquisitions of hospitals that were in need of substantial capital improvement, incentive and remedies to make these improvements probably constitute one of the most important benefits of the original transaction.

So, their post-merger review is likely to take time and resources, it may be useful to have a quick look, or preliminary investigation after which the FTC could issue a second request, and that might be one way to conduct a review while minimizing uncertainty for the merged hospital. But obviously the comments of the panel, I would be very interested to hear the comments of the panel on this.

So, thank you again for permitting me to make these remarks. I'm going to apply the FTC's post-merger review program, and I hope that my comments today will be helpful. I am also happy to answer any questions that you may have today and in the future.

Thank you.

(Applause.)

MR. KOPIT: Well, I guess I can close this, Lawrence. I'm going to try to play against type today and be relatively brief. Anything I knew, I said yesterday; I'm sorry you couldn't be here. But anyway, I do agree with Lawrence that the FTC's retrospective is an important one, and I want to focus on that, rather than the slightly more general topic of post-merger conduct.

And I guess the first thing I would say is from my perspective, the opportunities that I see in the FTC's retrospective are really two. The first is, and some of the things Lawrence said obviously go to this, it's an opportunity to view issues, important issues, in hospital mergers to date from a very different perspective from what we have looked at them before, at least for the most part.

And then the other opportunity I see is an opportunity to clarify or collect, I suppose it depends on your perspective, clarify or correct some technical errors that have been made generally by the courts to date in some of these cases.

And I say that without being critical in any way of the courts. District judges are generally, at

least in my experiences as a trial lawyer, as well as an antitrust lawyer, federal district judges generally are bright generalists. That's what they are. You rarely come across a federal district judge who is an antitrust specialist, at least not before you get there with your case that's very different from the ones he's been looking at.

On the other hand, the FTC, the commission itself, and its staff, have a particular expertise. This is what they do for a living and that should make a difference, and should give the FTC and its staff an opportunity to do things with opinions and with analysis that you probably wouldn't expect in the average district court case.

So, I do think that one of the important things that the FTC has here, is the fact that it is in a position through its litigation in these retrospectives to correct what at least a number of people think are technical errors in the analysis to date, and to look at these issues from a very different perspective, and hopefully get answers that perhaps are more satisfying.

Now, I, of course, don't know, I was not privy to the reasons why the FTC made this major change in focus or approach, but I have heard bandied about, at least in part, and one that I've heard that I want to

raise, if only to dismiss, is this so-called issue of the home-court advantage. Toby, I actually have no life at all, so I was listening to one of the other panels on the phone, and heard what Toby said the other day, and I agree with it basically, which is if people talk about the home-court advantage, I think they are largely missing the point.

It's much more -- it's much more complicated than talking about the home court advantage. And by the way, in this extreme form, and I have heard this, I won't name names, but I've heard this from staff people right here at the FTC, when they say, well, what this really is is the explanation of the judge goes to the same country club as the members of the hospital board explanation of why this happened to me.

And again, I think that very much misses the point and oversimplifies a lot more very complicated reasons for the decisions we've gotten to date.

Take a look, for example, at the Tenet case. I mean, the Tenet case is a case where the district court found that there was liability against the hospital. And the court of appeals reversed, without paying any attention at all to the district court's findings of fact, which is just a flagrant disregard of the standard review. But, I mean, it's hard to argue that

the Tenet case involves a home court advantage.

Look at Grand Rapids, if you will. I mean, the Grand Rapids case was tried not in Grand Rapids, but in Lansing, it's over an hour away, in Lansing, Michigan by a judge who lived in Lansing, not in Grand Rapids. It's hard to argue that there's a home court advantage there, because if the hospital markets are the same as the country club markets, at least according to the FTC, there would be no overlap.

But more seriously, I mean, I wouldn't limit it to that. The fact is that most people don't recall, but in the Grand Rapids case, the preliminary injunction was followed by an administrative complaint, which the FTC then itself dismissed. Now, you would have to ask them why they dismissed it, but it's real hard to argue that there was a home-court advantage there. So, I tend to dismiss this notion that if hospitals win, it's because of the home-court advantage.

On the other hand, even if there is or was a home court advantage, I think all of us would have to agree that by going at it in the first instance through a retrospective analysis in an administrative proceeding, trying a case at the FTC, rather than a court, certainly eliminates any home-court advantage.

Indeed, I would suggest that it puts an even stronger home-court advantage, you know, to the benefit of the FTC. It puts the hospitals at a very serious disadvantage. Much more so than the other way around, because I don't know any hospitals in any hospital merger case to date that's had an opportunity to try a case before itself. But of course that's the way the FTC operates.

And I say that not to, you know, deride what's going to happen. I have, you know, hopes for it, but I do think it means that the FTC has to be very responsible about the kinds of cases they take, and to make sure that the cases they prosecute are cases that they can show involve a clear consumer loss. Because otherwise, I think there will be criticism that what we're talking about is something other than, you know, an analysis on the merits, and I think that could be -- that could add great jeopardy to any serious notion of review of hospital mergers, either before or after the fact.

So, you know, that's just it is what it is, I'm sure that's what the FTC has in mind, but I think that's very important.

But as I said before, I do think that this process, the retrospective process does involve a way

to look at these issues very differently, and I think that's very good. When we tick off two issues, and probably say something about both of them, not much, but something about both of them, what's probably going to be different from what everybody else says, and that is, of course, one of the issues that's been hotly litigated to date is the issue of nonprofit status. Does it really make a difference whether hospitals are nonprofit?

If hospitals are nonprofit, do they maximize profits, or do they not maximize profits?

The other issue that's been very hotly litigated in the cases to date is the issue of efficiencies. How large are the efficiencies? Are they, you know, 10 percent, 20 percent? It seems to me that when you're looking from a retrospective position, those issues largely just go out of the equation. It really doesn't matter whether the hospital is for profit or not for profit, or excuse me, not-for-profit hospitals would act or can act differently than for profit hospitals.

It doesn't matter whether the efficiencies are great or small, particularly. It seems to me that the gut question, the question that's really critical in any of these is, whether or not prices have increased

above competitive levels. Now, remember, I didn't say increased, I said increased above competitive levels.

Obviously, we're assuming that all prices are going up to some extent, but the question is, are these prices -- have they gone up above competitive levels? If they haven't, I don't see the problem. And but if they have, the fact that they're -- the hospitals are not for profit, I mean, so what? I mean, maybe it could have acted differently, but it didn't.

If they're efficiencies, so what? I mean, high efficiencies, but they're not passed through to the consumers because the prices are higher, why do we care? The hospital didn't mean any of the things it said; on the other hand, you know, it said it was going to get $250 million worth of efficiencies out of this merger, and it turns out six years later it got 10. So what? If the prices are not higher, why does the antitrust law care?

Now, the third issue that has been hotly litigated, I think, is a trickier issue to think about in this context, and that's the issue of market definition. Arguably, it seems to me, if the FTC could show in one of these cases that prices are higher than they would be under competitive conditions, that's the end of the story. You don't have to prove a market, a

geographic market, which has been the contentious issue in these cases. Because you've got the results. You've got, by definition, in my case, prices that are higher than competitive conditions. And you've got a violation. And why bother with the argument over what's the size of the geographic market?

On the other hand, I don't think that the FTC has to do that to prevail in these cases. I don't think they have to show that prices are higher.

Let's go back to the HCA case. It's one of the few cases, if you can remember back that far, I think it was 1984 or something, one of the few cases where the FTC did go in retrospectively to look at a consummated in that case, not a merger, but a consummated acquisition. And awarded divestiture after the fact.

But that case wasn't tried on the basis of higher prices, that was tried in a rather traditional way for a merger case. The FTC said, the market shares have gone up to a whopping 24 percent. I mean, times have changed, but the market share of the -- after the acquisition by HCA have gone up to 24 percent, and now the burden is on the defendant to come forward and show why even though there's been an increase in market power, that increase in market power hasn't been

exercised in some way. So, consumers haven't been hurt.

That, to me, that same approach, if the proof is there, is still valid today in a retrospective. So, I don't think the FTC is actually duty-bound in every case to show that prices have gone up above competitive circumstances, not only gone up, but above competitive circumstances.

On the other hand, it seems to me that what we do have now, and what we didn't have in 1984, is pricing data that matters. Pricing data that's worth something. And that's the pricing data, as Lawrence said, we're not talking just about charges, we're not talking just about what's in your charge master, we're talking about the net prices that you're charging to managed care compared to the net prices that other hospitals are charging to managed care.

And that data is good in most cases now, and it is available. To say its readily available may overstate it, because I've been involved in seven or eight of these cases now, and the only thing that's constant in all of them is the third party payors, regardless of who they want to win, don't want you to have their data, because they think that you'll leak it and it will hurt their competitors and on and on.

So, it's not easily available, but it is available, and it's usually pretty good when you get it. Now, the problem is in this circumstance, that initially it's only the FTC that's going to get it. Because they'll subpoena it. And so the hospital defendants are put in an enormous disadvantage, or I say defendants, potential defendants, at the investigation stage, are put at a disadvantage, because the FTC has the data, they've gotten it through CID, and they can't share it, even if they wanted to.

So, maybe in the negotiations before a possible suit, they're saying, well, you know, looks to us like your prices have really gone up. And the expert for the potential defendant says, well, can I see the data? And the answer is no. We can't give it to you, we got it through CID.

So, once an action goes forward, presumably at that point the data is available to both parties, and at that point, the hospital's expert can look at it and try to point out any methodology in what the FTC has done, but to me it's very unfortunate that that can't be done before the fact.

But I do think in most cases that that data is available from third parties, and it will be a rich source of information.

Now, I guess going back to Lawrence's last point, let's talk -- let's talk about remedies. Now, initially, or up until very recently, when Chairman Muris announced this initiative, it was usually assumed and told to me many, many times, when I suggested on behalf of hospital defendants, golly, we really think this is going to work, we really think this is going to result in lower prices to consumers, not higher prices, why don't you wait and see what happens? And what we were told, of course, by both agencies, not just by the FTC, is oh, no, we can't do that, because you can't unscramble the eggs.

And so once this merger takes place, it's over. And so it's now or never for us and that's why we're rushing in. Well, I don't think that's the case. I don't think it's true in all situations of hospital mergers that you can't unscramble the eggs. I think there are certainly some hospital mergers where you can unscramble the eggs.

But before I talk about that for a second, I would like to point out two other things. The first is that unscrambling the eggs of divestiture is certainly not the only remedy. There are other options. Now, whether or not they're optimum options, I suppose, if you would think that, you know, they have something to

do with constraints or regulatory constraints in the sense that they're part of an order, a conduct order, yeah, they're certainly less than perfect.

But less than perfect is never, in life, in my mind, anyway, a reason not to do something; otherwise, I don't think we would do anything. So, there are a couple of options that are worth mentioning, at least.

The first one is, limits on the rate of increase of price, and again, when I talk about price, in this context, I'm talking about net prices to managed care for certainly to include them. That is an option as relief. The only thing I would say about it, other than conceding that it's certainly far from perfect, is that to do it effectively, you've got to limit it to commercial prices of managed care.

Once you say what we're going to do is look at all increases in revenue, on an average, you're basically giving away the store, because that means that the hospital is free to offset any decreases in reimbursement from Uncle Sam, who does it all the time to you, to offset it by an exercise of market power against commercial payors. And that really doesn't help you very much if you're looking for relief.

Another option that it seems to me is at least worth talking about is the option that the Justice

Department, nobody talks about it very much, but that the Justice Department imposed in the Morton Plant and Mease case, which interestingly enough is exactly the same remedy that the Supreme Court validated in the Citizens Publishing case.

For those of you who bothered to read the Citizens Publishing case, the relief is not to divest the joint venture, or the JOA in that case, and say that these hospitals -- excuse me, in that case these newspapers can't have a JOA, the relief was to say that they can't be joint pricing by the JOA. That's all the Supreme Court did. And so they can't be joint pricing.

That's exactly what the Justice Department did with Morton Plant and Mease. They said, oh, no, we're not going to let you merge, because under this very narrow definition of the geographic market that the Justice Department had, I'm not arguing it's right or wrong, but under that definition, there was market power, so no, we're not going to let this merger go forward. But we will -- but we will let you do a joint venture. And we'll let you do certain services and produce them together, as one, but you can't price them as one. Each hospital independently has got to price those services.

So, at least there's that element, there's no

competition other than the cost aspect, but there's competition over the degree of profit or loss, if one of the hospitals wanted to choose to take a loss on something. And that is certainly possible.

The problem is, it's hard to see how that's possible in an actual merger. It's possible, it seems to me, very likely, in a situation where you're talking about a JOV -- excuse me, a JOA, where you still have two remaining hospital facilities, and/or their parents, to price separately. But I can't envision it in a real merger where you only have, you know, a single entity or a single parent. I don't know how it would work in those circumstances, but it certainly could work in a JOA. Paragraph but again, looking at this from the perspective of the FTC, the problem I see with the FTC with that particular type of relief is that the FTC probably doesn't have any jurisdiction over JOAs, at least to the extent -- at least to the extent that they involve not-for-profit hospitals. And most of these JOAs, at least, are involving not-for-profit hospitals.

And I say that, because if you look at section 7, which of course says that the FTC does have jurisdiction under section 7 of the Clayton Act, what that says is sales of stock, no; sales of assets, no;

mergers, no, not really, it's not a merger, it's a JOA. There are differences, they are still separate organizations.

So, while I think conceptually it's still an appropriate remedy, I don't think it's conceptually an appropriate remedy for the FTC, because I'm not sure that the FTC has jurisdiction. You know, the FTC act, as you know, only covers for-profits, not-for-profits.

But anyway, let me end with one additional point, and that is, that under certain circumstances, divestiture is the appropriate remedy, and I see that basically if two circumstances. One is where the hospitals could have gotten substantial clinical efficiencies, but didn't. Think of the two hospitals three or four miles apart, say they had two emergency rooms, do you really need two emergency rooms in most towns where the hospitals are two or three miles apart, small or medium-sized towns, probably not.

But the hospitals just chose not to get that efficiency. They chose to get no other efficiencies. They just chose to continue to operate separately as totally independent clinical entities. There, for sure, divestiture should be appropriate, and what do you lose? Very little.

The other circumstance is a little more

difficult, but I think it's the same answer, and that's that hospitals couldn't really get very many clinical efficiencies. And the reason is basically usually they're too far apart. So, you know, you've got two or three hospitals, they've all merged and they're 15 miles apart, on average, each one. But they're in the same market. But are you really likely to get a lot of clinical efficiencies, reductions, you know, when you have hospitals that far apart? Probably not.

You're very likely under those circumstances to have very little clinical efficiencies. The hospitals maybe couldn't have done any better, but again, from the purpose of remedy, I'm not sure it makes any difference. The fact is that if those hospitals are divested, and they should -- you know, and again, you have to go to the question if they've violated the law. Of course, if they haven't violated the law, you don't divest them.

But if there's a violation, and there is no clinical efficiencies, even if the answer is, well, we really didn't have much opportunity, I'm not sure that's a defense, and I think under those circumstances, it would be appropriate.

Thank you very much.

(Applause.)

MR. TAYLOR: One of the easiest things to examine in terms of post-merger conduct is how long have the hospitals gone actually realizing the efficiencies they stated they were going to be able to generate or produce or realize as a result of this merger? And when that's been done, in general, the hospitals have not fared very well in terms of representing in perhaps a Hart-Scott-Rodino filing that they were going to save $100 million, and you look at them three, four, five years down the road, and they've saved maybe 20 or 30 million or something like that.

In fact, there aren't many cases in which you look at post-merger behavior in hospitals and you find that not only did they meet their claimed efficiencies, but exceeded them. And that really should be what we would expect to find, that they would do better than they predicted, and here's the reason for that. If they do a good resourceful job of very clearly defining the efficiencies available to them, they're realistic, they're well thought out, and management is committed to that course of action, there should be very little reason why most of that does not pertain to the benefit of the hospital as they had expected.

Now, I've looked at mergers in which the hospitals have paid six, seven, $800,000, $1 million

for a hospital efficiency study and the hospitals themselves have generated about 25 percent of the savings that that efficiency study said they could make.

Now, I know of nowhere else, other than antitrust, Hart-Scott-Rodino filings, where management would put up with that. If you hired a consulting firm to come in and say, we would like to save some money, we're going to pay you $1 million, show us how much we can save and where to do it, you've paid them $1 million, and three years later you were 25 percent of your way along the path, I'm pretty sure they would be coming back trying to get their fees back.

That doesn't happen in Hart-Scott-Rodino filings, and yet time after time I have seen situations in which they don't come close to realizing that which they have forecast.

Now, I said, gee, you should perhaps be able to do better than that. Why is that? Well, in a merger, when you do an efficiency study, you sit down, you go through the process, well, we still have two separate parties, we do some thinking, some planning, some forecasting, we come up with a number we're going to save.

In almost all situations that I have examined,

after the hospitals actually get together, something just springs up that nobody thought about before they got together. And so, there are additional opportunities to save some money. Now, perhaps not a lot, but at least there are things that could not have been forecast.

But one point that I would like to make today is, it seems to me that it's unreasonable to find very many situations in which you can't do what was included in the efficiency study, and yet like I said, that doesn't happen very often, in many cases. Well, I know, because I've looked at a lot of efficiency studies in hospitals. And one of the reasons I think that is there's an incentive for the engaged firm, cooperating on a Hart-Scott-Rodino filing, to come up with a really big number, a really big number. Because most of the people you talk to have in the back of their head, okay, DOJ, FTC, somebody, they want to see a pretty good number. And it's, I don't know, is it 6 percent, 7 percent, 8, 10, it's somewhere, they want to see a pretty big number.

And so, there's really an incentive to kind of get out there on the limb, on behalf of consultants, economists, those who are developing documents and analysis and support of efficiencies to be realized as

a result of that merger. So, there's a little bias on that thing in the first part.

The second part is, I think that one efficiency study is not really something which is approached or considered in good faith by a lot of administrators. I know of situations that I've investigated where there's been a merger, there's been an efficiency study, for whatever reason the merger went through and the efficiency study went in the bottom drawer and was never seen again. Never saw the light of day. We did that efficiency study for one reason, to support our application, it went away.

I have also seen an authentist, I have seen a situation where the day a merger was approved or a letter of termination was received, that thing came out of the drawer, and it formed a work plan. And it was, here's what we said we were going to do and we're going to do it, we paid a lot of money to get this plan and this is exactly what we're going to do and they went ahead and did it, kaboom, kaboom, kaboom, hashed it right out.

A lot of different approaches as to how that thing plays in. But a lot of the hospital administrators that I have talked with, worked with, believe that this is an important document, but we've

got to have a pretty big number, and so the number tends to be big. And perhaps many times, bigger than it really is defensible that it could be.

Now, I don't want to talk too much about the Grand Rapids hospital, because I think David is going to talk more about that, but I participated in the Grand Rapids hospital, and if you're aware of that, they didn't come very close to what they said they were going to do.

I'm not the least bit surprised that they're not very close to what they said they were going to do. Because in fact, I thought a lot of stuff they said they were going to do, there was just no way that was going to happen. They claimed a savings of 99 million dollars because one of the hospitals was falling down, Blodgett hospital. And it was going to cost more to fix it than build a new one.

You go to the Blodgett website today and there's 402 beds in that hospital accepting inpatients and we're about five or six years down the road from when they made that forecast that this hospital really needed to be replaced. That never happened.

Furthermore, a couple of things I find interesting about that situation is where they have found some savings. Some of their representations of

how much they have saved are just incredible. I think in pediatrics, for example, I believe they believe they're saving $800,000 a year. That's kind of incredible, because when they submitted an efficiency study, the total cost was less than $400,000 a year at Blodgett. So, how do they save that much money combining?

So, I'm not sure that some of those data are really good, but the point is, Blodgett and Butterworth, the Judge found that they were going to save over $100 million as a result of this combination. I don't know where they are now, but I think they're less than halfway there, but again, I'm not surprised.

Now, when I look at efficiency studies, there are two basic reasons why the numbers may be suspect. First off, a lot of savings are claimed that really don't have anything to do with the merger. Hospitals themselves could claim those. And as you know, the merger guidelines really don't allow for that. In other words, if hospitals are going to merge and they're going to claim a savings, it ought to be the result of the fact that we can't get there any way other than merge. That's the only reasonable way that we can, and then, therefore, is a derivative benefit of this merger that we ought to be allowed for, or that

ought to be allowed for to us.

But a lot of the reasons that -- and by the way, that type of savings, while it might be discounted in examination or analysis of whether or not it really goes to the benefit of -- occurs for the benefit of the merger is one case, but they may save that money anyhow, notwithstanding the fact that it may not be related to the merger. Some of the savings in Blodgett and Butterworth were savings -- they saved some money. Whether or not they had to merge to do that, I don't know. In many cases, maybe not.

But another real problem that is not feasible, it just would not work, but it was not properly tested. Another big thing of Blodgett/Butterworth has to be capacity constraints. Severe capacity constraints of Butterworth hospital. Unrealistic assumptions about how to manage that capacity in a way to make it more efficiently used.

So, the efficiency studies, to the extent that they can almost always rely upon in-house, on-hand data for their formation, ought to be pretty much off on the quantitative objective side of the continuum as opposed to the subjective side of the continuum. You don't have to make a lot of assumptions about a lot of things, because generally you're talking about things

we are already doing, we're going to do them better, here's how much we spent to do it before, if we put them together, we can do it a little bit better.

We've got the data in support of that, and the data ought to drive that decision. But, many times efficiency studies rely upon assumptions when they need not do that. And the assumptions are the things that perhaps provide a higher number, but at the same time, make that savings unrealistic, or something which would not be able to be obtained in actual practice.

Now, as I said, I've looked at a lot of post-merger efficiencies and compared them with what they said up front, and they're all over the continuum in terms of how well they have been able to jump in and satisfy that which they said they could do.

Unfortunately, the majority of the ones that I have seen have not come up to that which they had said they were going to do. They have not saved the 50, 75, $100 million that they really thought was going to come as a result of this merger.

And just in summary, then, the real reason for that is, almost always, either one of two things: Management was really never committed to that or at some point in time was not committed; or two, the plan that was set out was unrealistic, was one in which poor

analysis was used, and it was not well thought out to the extent that it never really had a chance to really deliver those savings as a result of that combination.

And then lastly, the thing that I find is curious is that hospitals will spend as much money as they did on one of these efficiency studies and now have higher expectations about their ability to be able to obtain those results. And that, for me, is the most interesting thing, that they spent a lot of money doing these things. If it doesn't work, they're not going back and asking anybody for their money; I think they should.

Thank you.

(Applause.)

MR. SMITH: Thank you very much. My name is Kirby Smith and I'm the President and CEO of Susquehanna Health System, which is located in Williamsport, Pennsylvania. Today I would like to review just briefly our accomplishments within Susquehanna Health System. We started our consolidation process back in 1993/'94. We are comprised of a community hospital, the Williamsport Hospital Medical Center. It started out back in 1993 with 325 beds, Divine Providence Hospital, located about one and a half miles away from Williamsport

Hospital, 225 bed acute care hospital, practically an identical clone of the Williamsport Hospital when it came to services, and we also had Muncy Valley Hospital, which was a Catholic hospital located in Muncy, Pennsylvania, servicing a variety of small communities.

In September of 1993, the Providence Health System, which was the Catholic parent, and the North Central Pennsylvania Health System, the community-based parent, announced their intent to join together and form Susquehanna Health System. One of the most frequently asked questions we have is what were the compelling reasons for the Providence Health System and the North Central Pennsylvania to undertake this alliance and the significant consolidation promises that were made by the hospitals?

The answer, first, was there was a business ripple in our community regarding the increasing health care costs in the late eighties. The West Branch Manufacturers, the Chamber of Commerce and others actually organized and carried on campaigns about the escalating costs of health care and pointed to hospitals in our community for their massive duplication of services throughout our region.

Second, both the community and Catholic

hospitals, which are only, again, a mile-and-a-half apart, had significant patient care duplications. Area medical staffs called for improved technology investment, and those monies simply were not available to invest in technology because of the competitive posture and nature of the wasteful duplication in our community. The physicians called for improved stewardship.

And then finally our community foundation, it's a $20 million community chest, if you will, cut off financial support to hospitals on any fundraising efforts until the hospitals could develop ways of collaboration and cooperation.

The system's mission, as we put it together, was to improve the health status of the communities we serve through high quality, compassion nature, accessible and cost effective care. Our vision was to become the healthiest community in the United States, and I will talk later about how we approached that. And our value statement was more of a focus. We knew that we needed to focus on those who received our care, and those who provided our services, which are our employees, medical staff and volunteers.

The sponsors, both Catholic and community-based, basically embraced the following

objectives: First, to eliminate the wasteful duplication of services; second, to lower the cost of health care; third, to increase the access to care. In the model that we were in, we were not necessarily addressing access. Fourth, enhance the quality of care, promote sound health policy, and to keep decisions about health care local.

We did put together an efficiency plan. I don't recall how expensive it was to put together, but it was a good plan that we felt comfortable with, and we took that plan to the Department of Justice, to the Pennsylvania State Attorney General, and we negotiated and entered into a consent decree which was filed in Middle District Court of Pennsylvania.

Some of the highlights were that we were to save $40 million in the first five years of our alliance ending June of 1999. That's a sizeable amount of money for the small, rural community that we live in.

Second, we need today pay the Attorney General in cash for any shortfall if we ended up at the end of the five-year period with a $30 million savings, we need today write a check to the Attorney General for $10 million.

Third, we needed a return savings to the

community, 60 percent the first year, 80 percent of the savings in the following four years. And fourth, the Pennsylvania Attorney General took a look at reports that we provided and made sure that we were in compliance with those stipulations.

During the first five years, we completely restructured health care in our region. We eliminated almost all duplicative overhead and patient care services that our system had. Some overhead consolidations that I would speak to today, and I'll only look to the ones indicated in red, but all of these, whether they be printed in red or black, were implemented.

First, our administrative staff was reduced from 34 vice presidents down to 18. We've reduced positions throughout the health system, not only overhead positions, but also patient care positions by over 450 FTEs within our area system.

Within human resources, we had a single set of policies and procedures which were developed and implemented, a single retirement plan. We gained some efficiencies by creating, because of the size of our health system, self-insured health benefits, thus eliminating our need to go out into the open market and purchase insurance.

From an information systems perspective, our information services department took on the responsibility of coming up with a single computer system to help manage our financial and clinical information systems. We're extremely proud of that system that we developed in conjunction with Siemens Medical. We have a single medical record for all three hospitals. That record is shared electronically amongst all physicians.

We also have clinical records in the physician office association that if you have a record with a particular physician, and you show up in the emergency room with a problem, it's possible for that emergency room physician to actually query up not only your stays in the past, but also any information that might be in the physician record in his office, if that physician releases it to the emergency room.

We've standardized all of our personal computers and all of our software. We take care of all of that.

Because of this initiative, we have found the favor of the federal government, and we have received over the past three years $2.2 million in grant funding or appropriations to help us roll out this computer system on behalf of our health system and our

physicians.

As we continue to look at overhead, our city medical staffs, there was a medical staff at the Divine Providence Hospital, Catholic, and there was also a second medical staff at the Williamsport Hospital Medical Center when the alliance began. In year two of our alliance, once they found out that the consolidations were clearly in process and were going to happen, they went ahead and merged the city medical staffs into a single organization.

We implemented such things as a single telephone system for all of our sites, which also allowed us to consolidate three switchboard areas into a single switchboard within our health system. Strategic planning, a very important aspect of our program, falls under the Susquehanna Health System board of directors, with a single strategic plan. Those board members and medical staff members help administration look at strategic initiatives. If a service is required to be offered in a community, where should it be put in place, should it be a duplicate service, maybe in diagnostic areas, patient diagnostic areas, certain things should occur in multiple locations in our region. However, if it's expensive technology, this would be the board and the place where

single investment in expensive technology would occur. That priority-setting is done in only one place, and that's the Susquehanna Health System board.

Some inpatient consolidations, again, we had two rehab, cardiology, two neurology, two oncology, we had two of everything. Again, we were like Noah's Ark, two of every service you can think of. Those were all consolidated. Probably the most significant, in red, had to do with the consolidation of OB/GYN services. As you can imagine, we each had both the Catholic and other than Catholic organizations in the community had OB programs. Clearly the Sisters of Christian Charity felt very strongly, they wanted to keep OB services. However, when we came into the alliance in '94, the Williamsport Hospital had just completed a several million dollar renovation and improvement of their service. For the Sisters to keep in the business, they were going to have to duplicate approximately a $2.5 million program, and they agreed in year one of the alliance to give up that hope, even though their women's auxiliary had raised probably $800,000 to help fund it. They gave up that opportunity so that the community could save those funds.

On the other hand, the Providence House is an outpatient service, if you will, where we work with

women in crisis pregnancies, and work with them so that they have a place to land. It's a safety net service so that those women that wish to keep their pregnancy to term can do so in the safety of a specific home. So, that is one of the aspects of our health system.

Other consolidations, we've consolidated all of our expensive laboratory services to the Williamsport Hospital Medical Center. At the bottom of that chart, we took on some additional savings. These were not originally in our plan, but pose opportunities to us due to changing census numbers, due to length of stay reductions in our community. We found ourselves in a position in 1998-'99 to actually move all of our medical/surgery patients to the Williamsport Hospital Medical Center, as well as our critical care unit. So, basically what was beginning to happen now in a real way was the Williamsport Hospital was taking on an inpatient flavor while the outpatient services were being consolidated at Divine Providence Hospital in the city of Williamsport.

Outpatient consolidations along with that inpatient, there were two emergency rooms, again, only a mile and a half apart. We closed the Divine Providence Hospital emergency room and consolidated that to the Williamsport Hospital. So, basically you

can see the Williamsport Hospital had the emergency room now and all inpatient services, except for psychiatric care, which remained at Divine Providence.

Other outpatient consolidations, home health care and hospice became the Regional Home Health Services, that really backfilled one of the inpatient floors that was vacated at Divine Providence. Also, the surgi center, Divine Providence went to only an outpatient surgery center, which took some of the outpatient surgery out of Williamsport and condensed it at Divine.

The cancer treatment program, again, mostly outpatient, all went to Divine, and you can see on these outpatient consolidations, without exception, all of these services went to Divine Providence Hospital in terms of eliminating these wasteful duplications, and please remember, we had two of all of these, just a mile-and-a-half apart.

Again, our quality focus was based on the fact that there were people in town that either went to Divine or they went to Williamsport Hospital almost exclusively for their care. We were taking their choices away through these consolidations. You were only going to be able to go to Divine for outpatient cancer care; you were only going to be able to go to

Williamsport Hospital for rehabilitation services, et cetera, et cetera, et cetera.

We know that the quality of care was a big concern of ours, and as you can see on this chart, we have continued to keep abreast with JCAHO surveys, CARF surveys, which is Comprehensive Accreditation for Rehabilitation Facilities, et cetera.

We also helped create the Lycoming County Health Coalition, which is a coalition of about 30 not-for-profit agencies within our community and their objective was to identify and measure the improvement of our county's health status. A very important aspect of our strategic plan, because where there were holes, we wanted to fill those holes.

One of the things we did is when we moved the emergency room from Divine over to the Williamsport Hospital Medical Center, we created a community health center at the request of the Lycoming County Health Coalition. That's a community health center that cares for the poor and the indigent. We had 11,500 visits last year, but probably more importantly, we took on a dental clinic, because there were also dental needs in the community that simply weren't being met. Primarily the poor, but also there were children with very significant needs, and they needed to be sedated for

the purposes of their dental care, and we took that responsibility on as well as other patient service improvements, so not only did we consolidate, but there were areas we improved. The Breast Health Center was an interesting one. We had a donor that had been aligned with the Williamsport Hospital for years and years. She wanted to give a very large gift to Williamsport Hospital Creative Breast Health Center. Our system board decided that that Breast Health Center belonged to Divine Providence Hospital. The donor was approached, a very high profile individual in our community, and asked if she would give that gift to the Sisters of Christian Charity so that that Breast Health Center could be developed on that campus rather than the Williamsport campus.

At that time, it wasn't viewed as being we/they, at that point in time, which was about year two, the donor agreed that she would, by all means, give that donation to the Sisters of Christian Charity, and she didn't care where the Breast Health Center was, as long as we had one in the community. And that was a great turning point for our alliance.

We also continued to grow our hospital within a hospital, and as you can see on the eye center, and the pediatric services, which were at Divine, that was

transferred to Muncy Valley Hospital as one of their centers of excellence, and it also provided us with more capacity at Divine for outpatient surgery.

This is a listing of a variety of recognitions, national awards that we have received as a result of our consolidation of services, and I'm not going to go through all of those.

At the end of the fifth year of our alliance, we had reported savings to the Attorney General's Office through June of '99 of $105 million. The return of those savings to third party payors and to the community was $117 million.

The questions that I'm frequently asked is, did the alliance, the merger, the consolidation of services achieve the efficiencies it promised? The first look is if you look at the inpatient side, look at the beds, certainly we delicensed a ton of beds, 57 percent of our beds that were delicensed. We went from 607 down to 287, but at Williamsport, which is again our primary acute care hospital in Williamsport, 241 beds is where we are today, average census probably in that 200 range or probably a little less.

Divine Providence Hospital is now an outpatient campus, it has 31 inpatient psychiatric beds, and that is it. The rest of the services we provide there are

outpatient only.

And Muncy Valley Hospital was 70 bed acute, now it's a 15-bed critical access hospital, located about 15 miles outside of Williamsport.

The second point that we look at is our cost savings. Our target was $40 million. We felt fairly comfortable we could make that. That's why we made that bet with the Attorney General. But we actually came in at $105 million, according to the report submitted. We returned $117 million, which was actually more than the amount saved.

And I would like to thank you for the opportunity of presenting that information. Thank you.

(Applause.)

MS. HOPPING: Hi, thank you for allowing me to present to you today. It is always an honor to be a part of any process that increases the understanding of the complexity that is health care. I commend the Commission for this series of meetings to better understand how health care markets work. I look forward to your final report.

Again, my name is Jamie Hopping, and I am the Chief Operating Officer of Ardent Health Services in Nashville, Tennessee. Ardent owns and operates acute care hospitals and behavioral hospitals throughout the

country. We currently have 27 hospitals in 12 states. Personally, I had more than 20 years experience in health care as a provider. I had run everything from small hospitals to a group of hospitals with more than $4 billion in revenue.

In regards to today's topic of post-merger environment with hospitals, I have been part of six hospital mergers. I have seen and been involved in highly efficient mergers, and as an industry observer, I have observed mergers that were not particularly well thought out.

I believe in the open marketplace and I believe in competition. Most of all, I believe in quality of health care. I would like to address hospital mergers from an operational standpoint. To be successful, a merger must achieve real, not just paper, efficiencies. Sometimes there's just a merger of balance sheets, but the two systems are run separately. They're obviously not efficient. The name becomes hyphenated, and unlike a merger where two people hyphenate their last names, there really is no merger that occurs.

In other cases, you'll see the executive suites merged, you'll see the balance sheet merged, but you won't really see an operational plan that's been prepared and planned for the merger.

In my view, a truly innovative combination of merged executive suites, balance sheets, operations, and clinical programs to be successful. Examples would be including eliminating tertiary services, such as open heart surgery, neuro surgery, neonatal intensive care, pediatric surgery, among others. Simply getting a consultant to put together a report versus dealing with the tough issues with physicians and staff allows for a development of an operating plan.

A true merger eliminates duplicative services and costs. As an example, at this point, we are putting together a delivery system in Albuquerque where we are eliminating women's and children's services from two hospitals to one hospital and dedicating one facility for women's and children's services.

Merging hospitals can bring substantial efficiencies; however, if the tough decisions are not made at the outset, mergers can be great failures.

The merged party has to be aggressive. If you look at the UCSF/Stanford merger, and I watched that from afar, it unraveled, and it appears that they didn't make the tough decisions at the beginning.

I worked on behalf of the California Attorney General on a proposed merger between two systems in the east bay of San Francisco. They indicated that they

were going to consolidate their open heart programs. At the time of the proposed merger, it didn't appear that they had had face-to-face conversations with the affected physicians, the cardiologists and cardiovascular surgeons. There was no plan. There was a consultant's report. And the consultant's report had indicated that there were a number of opportunities that this particular consultant had never actually done a full-fledged hospital merger and didn't really have the expertise, and it didn't appear that that consulting report had really been carried through to an operational and a management plan.

In a case that I was involved in in south Florida, we consolidated two hospitals. We purchased one hospital and consolidated our existing hospital into that hospital, Palm Beach Regional and JFK. We own Palm Beach Regional, we bought JFK, we closed Palm Beach Regional less than 60 days after making the acquisition of JFK.

We had a very specific plan, it was our fourth merger in that marketplace, and we had local knowledge and expertise. I don't recall using any consultants to accomplish that.

And when I put together the various learned lessons from the mergers that I have been involved in,

the key operational issues, some of which provide efficiencies and some of which are just difficult issues that have to be dealt with, include closing facilities, making that very, very tough decision, combining hospital-based physician groups, these are sometimes the toughest issues that you have to deal with in a merger, and that means getting radiologists, anesthesiologists, pathologists, ER physician groups, and neonatologists together to provide services in the new combined entity, providing one set of medical staff by-laws. Again, it sounds like something easy to do on a checklist, and it's a very tedious and difficult process at times.

Consolidating contracts for health plans, staffing, combining governance, communicating with one voice, because you have two entities who have local community knowledge and all of a sudden they have to be able to communicate as one entity.

Changing the culture, again, it sounds like something on a check box, but it's something that goes on for years and years and years. Consolidating provider numbers, all of the regulatory requirements, improving quality by adding programs that were not efficient given increased bulk.

As an example right now, we're combining two

laboratories that we're doing reference testing. They are now going to be able to bring in certain tests that as independent organizations they weren't able to provide or weren't efficient to provide, so they're able to bring those in-house.

Other areas, such as common quality benchmarks. Oftentimes in a single hospital environment, they don't have the bulk to be able to go after some of the quality indicators, such as ER wait times. There's also ability to improve access to information by investing in IT systems that the single stand-alone hospital was not able to do and which obviously involves a very large capital investment.

I believe investor-owned companies are better because they're willing, and in some cases able, to make some of the tough decisions.

What does all this mean in terms of the impacts on health care? Health care is a service that is paid by third parties, as we know. The federal government, Tom Scully, I think, in these hearings, on February 26th, said that the government is the biggest price fixer. As he said, one in three dollars in health care comes from the federal government.

Even private insurance sets prices to reflect federal government payments and they ratchet their

rates to the federal government rates. And obviously in Medicaid, they have a great impact on pricing, and depending upon the market, physicians do drive the volume, they do drive choice, and then, of course, patients have their choices and will move if they're not getting the service and the access and the quality that they demand.

My observation is that in the early and the mid to 1990s, hospital mergers were fashionable. In fact, many stand-alone hospitals were fearful that if they didn't become part of a system, they would fail. And there was a bit of a merger mania in our country. In some cases, the mergers were necessary to ensure a hospital's future. In others, it was a paper merger, that in fact resulted in inefficiencies for the new combination, because you had to have new executives and new corporate offices and new suites.

Hospital care is a highly fixed cost business; therefore, there are logical efficiencies to be obtained through mergers. In some cases, whole hospitals can be eliminated, resulting in very high efficiencies. In other mergers, programs, management, supply purchasing, debt consolidation, and labor, can result in huge savings.

Finally, failed mergers abound where the

combination was made without a detailed plan of execution that resulted in new efficiencies, and in some cases higher costs. With hospital mergers, there must be a plan. Management and the board must make hard decisions. They must be aggressive and must keep in mind the audiences that impact health care.

I want to thank the FTC and DOJ for the opportunity to discuss my personal experiences in effecting hospital mergers. Thank you.

(Applause.)

MR. WIEGAND: We're going to pause for about an eight-minute break, probably not long enough to grab ice cream, but long enough to get up and stretch and refresh ourselves. Thank you.

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

MR. WIEGAND: Jim?

MR. LANGENFELD: Thank you. And thank you for the opportunity to be here. It's always nice to be someplace where the weather is worse than Chicago.

I would like to talk about post-merger behavior from an economic point of view. And actually, from an academic economic point of view, oddly enough. But that has applications, I think, going forward, in terms of FTC policy, and just competition policy in general.

So, I'm going to start out by making some very rough characterizations about what I've observed in some markets after mergers. I am not going to talk about anyone in specific, but I will just give you a general characterization.

I'm next going to talk about what the courts, in a very simplistic way, to some degree, but the way the courts have looked at doing market definition, geographic market definition, in particular. And to some degree, some of the discussions that talk about competitive effects after a merger that I have found in some of the court decisions.

What I'm going to talk about is, okay, the FTC is engaged in post-merger investigations. Now, obviously, the DOJ is helping sponsor these hearings. What can we learn that might inform us, looking forward, what economic facts might we get out of retrospectives? It would be helpful to test what are the approaches that the courts have taken to this point in time actually make sense or not. Then I'll have a few words for why I think in particular the FTC and the DOJ are in a particularly good position to do this type of research. I'm not going to recommend whether they should be bringing administrative law complaints or not.

So, this is definitely not all mergers, not even most mergers, but some mergers, what I've observed is this: Pre-merger, perhaps the acquired hospital has lower rates to private payors than the acquiring hospital has. After the merger, the acquiring hospital raises the rates up to its higher level, which on average is a price increase. And I have also observed that these rate increases can be as much as 50 percent, or sometimes even more. So that there is actually a noticeable effect.

Now, this is not based on doing detailed econometric analyses, although some people, such as Mike Vita and Seth Sacher, who is going to discuss his work, have done that. Perhaps the first time this merger retrospective test was ever done, several years ago, shortly after I left the Commission. But those are -- I'm going to say in instances where we've observed these type of things, and as Lawrence points out, it's not necessarily easy to quantify all these things, but I'm going to make it simple, because I'm an economist and I can make assumptions. I'm going to assume that we observe this type of behavior in some markets. And if that's the case, what would a merger retrospective, once it establishes these things, what can we learn from it?

I see so many people whose faces I recognize, I'm not going to go through and talk about the basics of market definition here, with the exception of just making one point. The one point is that if we use the merger guidelines market definition type test in play at the hospitals, and places where the government is not price fixing, then the test basically can be a critical loss test initially, which is consumer price increase of some magnitude. Critical loss will tell you how many people, how many sales have to be lost in a hypothetical market, with everyone in that hypothetical market, all the hospitals in that hypothetical market, raise their prices at the same time to 5, 10, 15 percent higher.

The key thing that needs then to be addressed is assuming this price increase, and we know that it would not be profit maximizing if more than some level of people leave the providers in a given market, how much -- how many people would leave, to find out whether it would be profitable to raise price post-merger. And so, you need to get an estimate of the cue, what is the change?

And that's difficult in hospital mergers, although there's a lot of data identifying detailed price data, actually setting true transactions price

data is not that easy. And a lot of times courts just don't have that information up front. So, what do the courts do? The courts rely on the data that they have. Sounds like an economist, right?

So, they look at typically Elzinga-Hogarty type tests, where they follow basically patient draw areas and patient exits. And they measure those because in most states, there is very good data as to where a patient comes from to go to a hospital, and where -- and so you have that fairly detailed and reliable information. And although Ken Elzinga and Tom Hogarty didn't always say that this was going to be the be all-end all test, it seems to have been for many courts.

If it turns out that in a given market if more than, for example, 10 percent of the people leave the area to go to hospitals outside the area, then the courts have frequently found that that's too small a market area; you need to expand the area and include more hospitals.

Also, there's an overlapping draw analysis that's been used in some of the cases, too, which I'll describe, but it gets at a lot of the same issues that the Elzinga-Hogarty test gets at. But the key is that the courts have frequently just looked at these type of

benchmarks, plus some qualitative information, to make a decision as to what would happen in the dynamic sense. What if prices went up? Well, we don't know, but we're going to look at these patient flow measures and we're going to infer from that what was going to happen. And if enough people were going to leave a geographic area and go to a hospital outside of it, right now, we're going to assume that a price increase would induce many more of them to leave, and therefore the geographic market is defined too narrowly, it must be expanded. In most of the hospital mergers that have been lost, the half dozen or so that have been lost by the Department of Justice and the FTC have fallen on this geographic market argument, where the courts have found very broad geographic markets.

This is the only data I'll actually use in this and this is purely for illustrative purposes. To think about the Elzinga-Hogarty style analysis. These are from OSHPD data, and this is a merger I worked on, and like several people in the audience worked on. It was a merger between AltaBates and Summit, AltaBates being owned by the Sutter Health System.

What happened here, all I've done is I've calculated what a 90 percent draw area is, to keep this symbol, for the combined AltaBates/Summit hospitals.

And this is what it looks like. As you can see, the analysis usually involves zip codes, because zip codes are the smallest areas that you can identify where a patient is, typically. And this particular graph sort of illustrates some of the problems with draw area Elzinga-Hogarty type analysis. You can end up with holes in it, you don't necessarily get a continuous area. There are all kinds of problems with it, and I am working on a paper with Ted Frech right now that addresses some of these things. Ted has testified and mentioned that already in these hearings.

I don't want to go there, but what I want to say is let's think in terms of post-merger behavior and let's think about what the courts do beforehand. They look at these different zip codes; they say, okay, if you use an analysis similar to what Barry Harris uses in his critical loss, he will look at these and he will say, well, okay, we're going to start out and we're going to see whether any one of these zip codes in this draw area should be considered in the market, or definitely should be considered in the market is what they would say, but should hospitals outside this area then be added, too?

And the typical analysis that Barry has used, and successfully, in court, is that 20 percent of the

patients in any one of these zip codes actually go to hospitals outside of that zip code, well that's a contestable zip code. If prices -- if the hypothetical monopolist raised prices, the hospitals within this red area, raised prices, by 5, 10 percent, the argument is that enough patients would leave and go to hospitals outside the area that those hospitals should then be added to the market area and the area should be expanded out.

And of course the broader you expand it out, the smaller the market shares that any two hospitals will have, and it will fail on either defining the market or having the merger leading to a high enough market share for there to be an antitrust concern.

An alternative approach which I call the overlapping draw area analysis is basically a variant of this. If you look at the circle in the center here, that's a 90 percent draw area, let's say, to keep it simple. And there are other hospitals located around it, giving them all a mostly circular, sometimes elliptical draw areas. And the argument here is that if you have a hospital outside and the 90 percent draw areas overlap substantially, that other hospital should be included then. Because the patients that are located in the areas I've noted by As here could go to

either hospital. So, therefore, you should expand those hospitals out, you should include those.

This type of analysis, though, leads well down the road, because you can see there are other hospitals that have other overlapping draw areas. And when the courts embrace this, they say, well, you know, the market just keeps getting bigger and bigger and bigger, because you can always find an overlapping draw area. And, in fact, the courts have said, well, I've highlighted the circles to the right and the lower left, and this type of analysis leads you to include those, because the presumption is that there's a direct link here, that the prices will -- that people won't, because of this analysis, people will continue to migrate to further and further out hospitals if prices went up in the area defined with the As in it, that initial draw area.

And so it leads to surprising results such as, you know, half a state being a relevant geographic market for a particular hospital merger.

Okay, so what can post-merger behavior tell us about these two key tools that the -- that the courts have used in determining whether the size of geographic markets, which in the last 10 years have been fairly large. Well, one thing you can do is you can look at

migration responses, you can put a test to these type of tools. You can say, okay, based on my observations, the prices went up substantially, we should observe whether people actually migrated to hospitals further out. The economics part, that's a testable hypothesis.

If those migration patterns don't change, then we have to think about the assumption or the tool that the court is using at that point in time. Similarly, some courts have rigidly followed a 5 percent price test that's in the merger guidelines. Post-merger, if we take my hypothetical again, we observe higher prices than that. And there's a reason to think that that should also affect geographic market definition analysis by the courts if they're going to hold to a strict 5 percent test.

Let's talk about the first one. I think there's an important -- this testing, whether patients after a price increase actually change their migration patterns, is a very important thing. In part, because of my observations, we can have a discussion on this, but the hospital services are typically not homogenous, so there's no reason, oh, to think for a relatively small price increase everybody is going to go to a hospital at a more distant location.

Secondly, patients clearly have

nonprice-related reasons for choosing a hospital. It may be that they may travel a longer distance because it's located near a family member or work or there are things that make some of these longer migrations not necessarily sensitive to price.

Third, payors really do not have an unlimited ability to induce patients to switch. They can switch, they can provide incentives and today, I mean, there can be a differential, but it's limited as to how far you can get someone to go to a hospital. Therefore, my opinion is that there shouldn't be a presumption that because you have a certain market share in a zip code that a 5, 10 or 15 percent price increase will automatically induce enough exit to hospitals outside that the market should be expanded to include those other hospitals.

And in fact, in a post-merger -- in a review after a merger, you can test that. You can see what happens with the patient flows once you establish what the prices have actually changed.

Price increases greater than 5 percent, we can talk about several of these ideas and the economics are in some of the articles that I have provided to at least the panel here, because I wrote an article with Wenquing Li about critical loss and things. But it's

clear that the economics are that a price increase of 10 percent or more can be profitable, even if a 5 percent increase, the ones that some of the courts have strictly used, is not profitable.

That is to say, you can end up losing a certain number of patients, but if you end up with another group of patients that are priced in elastic, and you still retain those, you can lose a fair amount of output, you can lose a fair amount of patients and make a price increase profitable at a higher level than 5 percent.

And we can talk about that later, but once again, and this is in the area of economics, but I don't have time and most people don't have the interest to go through the details of that right now. It's a Friday afternoon.

But this is another thing that can be tested. You can see whether those prices went up by more than 5 percent by doing the initial analysis. And if they did and they were profitable, again that is evidence that the geographic market is narrower. It in some sense goes to the bottom line that Mr. Kopit was talking about.

There's also another thing the courts talk about, although typically this is not the reason they

throw out these cases, but, you know, judge's decisions being what they are, they talk about a variety of things. Sometimes they talk about what the competitive effects are. Let's assume you've established a market. The way you establish a market is, you see everybody raises their price at the same time. But once you've established a market, then you consider the competitive effects. How will the other firms react in the market, and will you price in some different pattern that's generally assumed when you're applying the merger guidelines?

And a lot of times, well most of the time, the analyses in the courts are that even if you have a market, where the hospitals and a firm -- this is a unilateral effects, not collusion -- the firm raises price substantially after the merger, because it has a large market share. Other hospitals wouldn't follow that price increase, and they would just take sales away from the hospital that attempted to raise prices.

Another thing is that they would assume that they would expand services, or expand the geographic reach, should a price increase take place. These types of things are important because if other firms, even if they had relatively small shares, expanded their services and took sales away from the merged hospital,

then that means that even if you had a well-defined market, which we typically don't have, and according to the judges in these cases, you still could defeat any attempts to raise prices in an anticompetitive fashion after the merger.

Particularly some specific tests, once again, if you have the benefit of looking at what's happened after the mergers, and I'm going to do that real quick here, because I'm running out of time.

The bottom line is that you can check, if you get you have enough information here, you can check whether other hospitals raised prices after the merger took place, or they did not. You can test that hypothesis. You can see whether they expanded services, as some Judges said that if prices went up, they would just expand, they would add another clinic, they would add this. You can test that, you can see by looking at the other competitors whether this type of analysis is correct.

So, let me just put it this way: One of the things that I really commend the FTC on doing this, not only for law enforcement purposes, but for the purposes of what I perceive the FTC to be, which is not only a law enforcement agency, but an agency that was created by Congress with special expertise to help figure out

hard problems, and I think to the extent -- and we shouldn't lose that aspect of it, and I think that's one aspect that should probably be useful based on the hearings that you're having here, and on the post requiems, on these mergers that have taken place. It can help understand how these markets work and can understand much better how the tools the courts are currently using, whether they're adequate tools or not.

Thank you.

(Applause.)

MR. BALTO: I'm David Balto from White & Case, and I don't know about the rest of the audience, but I'm rather disappointed that I didn't find out what a kinked demand curve means. I'm not an economist, I'm a lawyer.

I used to be the assistant director for policy and evaluation at the Bureau of Competition in the FTC, and background 2000. Emily Gertzima and John Simpson had the privilege of going to Grand Rapids, Michigan and figuring out what happened to competition after the Butterworth and Blodgett Hospital systems merged. To prepare for my talk today, I went back and spoke to some of the same people I spoke to back two years ago. By the way, for those of you who think I talk too fast and have trouble taking notes, everything I say is

included in two articles that I've written that are out on the front table, and then there's an antidote to my articles written by an attorney for the Butterworth Hospital system which takes the opposite point of view.

I was asked three questions to answer; I will answer them quickly. How effective is it for hospitals post-merger to switch to other hospitals? Well, at least payors to switch to other hospitals post-merger? The answer to that question in Grand Rapids is no. Are there -- how effective are nontraditional remedies in stopping anticompetitive conduct? The answer is maybe, for a short period of time, but you should always remember a merger is forever.

In September of this year, the sword of Damocles will fall upon the health care community in Grand Rapids, Michigan as the order that the judge imposed in the Butterworth/Blodgett merger is removed.

Well, let me give you the background, that was the bottom line, let me give you the background. In 1996, in the mid-1990s, the community of Grand Rapids realized they had a problem. They had a medical arms race between Butterworth and Blodgett, two equally sized hospitals, that were both very efficient, effective competitors.

To deal with this medical arms race, they

brought together a group of community leaders and they decided that a merger was the best solution to this medical arms race. By the way, there are two other small hospitals in Grand Rapids, but Butterworth and Blodgett at the time made up something like 60 percent of the total beds. No one else offered tertiary care. The FTC staff from Seattle, Washington, of all places, examined the merger and decided to challenge it. And the case went to trial in September, the parties were ably defended by Bill Kopit, and the court said that the FTC basically won. There is no question that this merger would result in a firm with substantial market power.

But, even though competition may be lessened, the interests of consumers were likely to be advanced rather than hurt. How did the court reach this conclusion? It reached it through some novel defenses, which really haven't been successful in other settings. First of all, the court said because these two hospitals were nonprofit, and there was a community involvement in the boards of directors of the hospitals, this community involvement would lead to make sure that any kinds -- that there wouldn't be significant price increases, and efficiencies would be passed on.

The court looked at competition from managed care. Managed care from the perspective of managed care, and said, the kind of selective discounting that goes on when managed care plays off two hospitals against each other was not the kind of selective price advantage that the antitrust laws were designed to protect.

I would like to use that all the time when I get to attack for price discrimination.

On nonprofit status, the court unfortunately couldn't be informed by Seth Sacher and Mike Vita's study, which came out a few years later, which severely questioned the empirical basis for assuming that nonprofit hospitals wouldn't raise prices.

Now, Bob Taylor has dealt with efficiencies. The efficiencies were mostly capital avoidance counts, the avoidance of capital expenditures, and again, the community commitment was assured that the efficiencies would be passed on to consumers. Finally, the critical unique element of this case was that the parties agreed to enter into a community commitment in which they agreed that prices would be kept for a seven-year period of time, and that there would be a community board involved to make sure that the commitment was met.

The commitment also created a complex pricing formula for managed care. You see, there's a unique problem in Grand Rapids, Michigan, that's unlike the rest of the hospital mergers that are being discussed. In Grand Rapids, Butterworth and Blodgett own their own managed care subsidiary, and though the FTC did not litigate the question of whether or not this merger would be anticompetitive at the managed care stage of this level of the market, the court was concerned that there could be adverse effects on other managed care providers through discriminatory conduct by the merged firm.

So, the community commitment was a cap on prices to consumers, and then a nondiscrimination provision, an extraordinarily complex nondiscrimination provision to make sure that Butterworth/Blodgett, now known as Spectrum Health, did not favor Priority, its managed care subsidiary, through discriminatory practices.

Now, five years later, what's the result? Well, first of all, Spectrum's market share has increased somewhat. It's something like 70 percent. It's increased, actually, a little bit over the last few years. The most important change in the marketplace is that Priority has grown from being one

of four or five managed care providers to the largest of a market which has only three managed care providers. And Priority has a market share of over 50 percent.

There has been withdrawal of at least one significant player in the managed care market, and unlike other markets in Michigan, there has been very little HMO penetration.

Now, there are good aspects and bad aspects of the approach taken by the court. On the good side: The parties really are committed to abiding with the community commitment on prices. There is nary a soul in Grand Rapids who will tell you that they are improperly increasing prices to consumers. Moreover, they established a transparent process of going and trading with an independent auditing committee and providing reports to the community on an annual basis about both cost savings and their commitments to keeping prices down.

Second, in terms of efficiencies, as Dr. Taylor noted, the greatest efficiency they proposed was that they were going to consolidate facilities. They were going to close Blodgett and consolidate all the facilities at Butterworth. That has never happened. The reason it never happened was that the physician

groups were not the least bit interested in having Butterworth closed.

Instead of that, there has been significant actual increase in investment in new facilities. Now, I have to say that the parties report that they have achieved over $300 million, let me repeat that, over $300 million in efficiencies during the five years since the merger has been -- the merger occurred. It's quite striking to me that that's so significantly greater than their estimates.

As to price caps, as I've mentioned, they seem to abide by the price caps, though there is some concern that they have been recharacterizing services, and on recharacterized services, that you come up with new services, those services are not capped.

Now, the impact on managed care is far more ambiguous, and there is a significant concern in the community articulated by some employers that Spectrum has been favoring Priority and that this has resulted, overall, in an increase in managed care premiums. A recent example publicized from last November, or last fall, occurred when Priority -- when Spectrum went to BlueCross and BlueShield, demanded a 15 percent increase in rates or it would be terminated in 60 days. Ultimately, they reached an agreement almost at

midnight of the day that they were about to be terminated with a substantial increase of something over 10 percent.

So, the problem with the merger, and it's a problem that lives forever, that cannot be regulated, is that before managed care providers could play off two large hospitals against each other, after the merger, that kind of ability to play off two hospitals against each other is just gone.

Priority is the only firm that has a capitated contract with Spectrum, and you have no independent agency to independently review whether or not the nondiscrimination clauses are actually being abided by.

Well, what about the effectiveness of price regulation? I think it's moderate, and in some respects, it appears to be quite effective. These people, you know, the firms involved are quite diligent about abiding with their commitments. However, after September of 2003, community in Grand Rapids will have to deal with, you know, a firm with substantial market power, and they'll learn the real meaning then -- some people said that they will learn the real meaning of the word "monopoly."

Now, other speakers have mentioned how praiseworthy it is that the FTC is considering

addressing these cases in administrative litigation, and I have actually written to that effect, but I wanted to raise three concerns for the FTC to consider in administrative litigation. And you see this in part in looking at the cases they're currently litigating.

I think that some of the legal standards that the FTC is applying would be inept in applying in a hospital merger context. And the FTC should consider the fact that they didn't lose these cases just before federal district court judges, they lost these cases before federal court appellate court judges. And no matter how good these administrative decisions are, ultimately the real tribunal is a federal court appellate court.

First of all, in the recent FTC administrative cases, they have taken the unusual position of saying that they don't have to prove actual anticompetitive effects, that they can continue to rely on the incipiency standard. And part of it is from the reasoning in the Hasbro Corporation of America where Posner says that you should discount evidence that is within the parties' control. So, if the parties haven't increased prices, that's not necessarily a plus for the acquisition, because they can control the increase in prices.

Regardless of whether the government could actually win a case like that, that was -- that had been consummated, five, six, seven years down the line, I think it's incumbent on the government to go and to identify cases where there's actually been a substantial increase in prices.

Second, I think it's very important for the government to actually litigate the issue of remedy, and how remedy would work. In the recent Chicago Bridge case, the government abjured the obligation of actually litigating how the remedy would work, and I think that would be a mistake for the government in a hospital merger case, and again, you know, it could cause problems later on in administrative litigation.

Finally, I think the government should do a careful analysis of both service and -- of nonpriced related aspects of competition, including service, quality and choice. Sometimes we assume just because choice is limited that that's an anticompetitive effect, but I think you need a much more careful analysis of both service and quality.

Thank you very much for having me participate in today's hearing.

(Applause.)

MR. SACHER: Okay, nothing like being the

eighth speaker on a Friday afternoon and getting to talk about econometrics, but basically it's a light and bouncy econometric piece.

(Laughter.)

MR. SACHER: So, I will start talking about it. Basically, I'm going to talk about two topics. First of all, I want to talk about some of my own research actually evaluating post-merger conduct. And this is actually the first piece of output from the FTC's merger retrospective project.

We look at a merger in Santa Cruz, California, the piece is called, "Vita and Sacher, a Case Study Evaluating Post-merger Behavior in Hospitals," something like that, I don't remember, Journal of Industrial Economics, 2001. And Lawrence kind of did a nice introduction because he told you what you had to do to write a good piece evaluating post-merger conduct, and this is it. It's all in there.

(Laughter.)

MR. SACHER: And then I just want to talk about some of my other pet peeves about how we might want to evaluate post-merger conduct, I think Jim Langenfeld actually touched on a lot of those kind of topics as well.

The Vita and Sacher paper, I think, makes

basically three contributions. One is on the effects of mergers generally. Believe it or not, there's really very little literature out there actually evaluating the post-merger effects of mergers in general. In a sense that's not surprising, because you guys here at the FTC or DOJ, when you see an anticompetitive merger, you evaluate that before it actually happens and you prevent it from happening.

So, us poor economists, we don't actually have that many anticompetitive mergers to look at to figure out what those kinds of effects are. So, that merger is actually fairly scarce. But we took care of one of those unfortunate opportunities for the consumers in a particular area, but a fortunate one for us economists.

And then quite obviously, specifically, the paper looks at hospital mergers, so it makes contributions to evaluating the effects of hospital mergers in general. And then third, it also makes a contribution because it looks at the effects of mergers between nonprofit entities. There's basically two kinds of theoretical arguments, or several kinds of -- two camps of theoretical arguments out there.

One that says that nonprofit entities will not behave like for-profit entities. Perhaps they are run by the community, and therefore, since they are run by

the community to give consumers a better break, they actually won't raise prices, they won't behave like profit-maximizing entities.

There's another strand in the economics literature that says, no, no, no, nonprofit entities will behave just like for-profit entities. There may be many reasons for this. One is that they may actually, you know, while their by-laws say we're nonprofit, in fact, profit-seeking entities may have captured them. In the case of a hospital, perhaps the hospital administrators or the physicians have captured it, and they actually want to run the hospital so that it earns profits and then they can turn those profits around and pump them back into making nicer offices or nicer equipment for you to work with. That's one possible theory of why a nonprofit entity may still seek to maximize profits, or at least increase profits when it can.

Another theory is that even a charity-run nonprofit entity may seek to increase profits and may use those profits for charity care, but still, nonetheless, may be behaving just like a for-profit entity. So, these are, again, just a sample of some of the theories that are out there that really are calling for empirical kinds of work.

As I said, the Vita and Sacher paper is one of the first papers to really look at an actual hospital merger, but there are actually a lot of studies out there on hospital competition. And these I've broken into basically two kinds of studies. The first, before the mid-1980s, I call them early studies, and these studies actually looked at the number of competitors and actually related the number of competitors to the costs. So, what hospital costs were like.

And the idea here was that there was something perverse about competition in hospital markets, that people weren't really price conscious. The way insurance worked, you weren't led to care about price. You came in there with your insurance policy and you were, you know, you went in there and you got your service in the hospital and you were reimbursed for your service, regardless of what it cost. You didn't have any incentive to minimize costs, and neither did the hospitals. And actually you had a perverse incentive in that hospitals compete in this medical arms race. They compete to increase perhaps just the amenities, or would compete to increase the expense of equipment, the kinds of facilities they had, and therefore, actually more competition had this perverse effect of increasing cost. And these pre-1980 studies

did confirm this hypothesis.

Around the mid-1980s, the insurance reimbursement system started to change for a number of reasons, one of which is California actually allowed selective contracting. The DRG system in Medicare actually led to other insurers experimenting with cost controls, and just a general sense that hospital costs and medical costs in general were getting out of control. There was a change, in that insurers started forcing patients to be more price conscious, giving them kinds of payments, copayments, and then deductibles, and also there was more selective contracting going on.

So, later literature actually looked at the extent of competition and price, and found it kind of standard relationship that we antitrust enforcers or we antitrust practitioners like to think, that the more competitors you see, the lower the price is going to be.

Okay, this literature is well and good, but it may not be entirely relevant to merger policy. One is that there are econometric issues. Anybody that's taken industrial organization, kind of the economics and antitrust, you spend about one quarter of your first semester or half of your first semester trashing

these price or profit concentration studies. Maybe now it's just so trashed that they don't bother mentioning it anymore, but at least, when I took industrial organization, that's what you did.

Not the least of which, one issue with these studies that may be relevant for hospital markets is that you're forced to define a geographic market and that's clearly not an easy matter. There's been obviously a very contentious issue in a number of the recent hospital cases that have been brought here, and actually the methodology that we use obviates the need for defining geographic market.

Secondly, just because you're looking at the number of competitors and looking at these kinds of price variables doesn't mean you're actually evaluating the effects of a merger itself. A merger can have, you know, contradictory effects. On one hand it can reduce the number of competitors, as well as these cost savings. So, what's the net effect? Just because you're looking at different markets with different numbers of competitors doesn't necessarily translate directly into the effect of a particular merger in a particular market.

And then I just would mention here, also at least one major study found this relationship didn't

hold for nonprofits. This study is by the only economist health care consultant that is not on today's panel, Bill Lynk, and he had the famous study in the Journal of Law Economics on that. His study, of course, was I think quite important, of the Butterworth decision that David Balto talked about. There have been other studies in the wake of that that have contradicted this result as well, using the price concentration methodology.

Just quickly, while I said the post-merger literature is fairly scarce, there have been some studies, some of them actually have taken place here at the FTC, and there's been basically two approaches that have been used. One is what I call a relative price approach. As Lawrence said, if you want to do a study of prices, you can't just look at average prices before the merger and average prices after the merger, because all kinds of things that are going on that the economists and the practitioner has to try to hold constant.

And one way that has been done in the literature is to look at -- you've got this particular good where the merger occurred, you've got the prices where the merger occurred, and to look at it in another market that is supposed to have the same demand and

cost conditions, the same kinds of things that would be affecting price. And look at how that price in the market where the merger took place changed relative for the equivalent good in a market where the merger did not take place.

And there have been basically at least two studies on this part, and Sherman did this in the microfilm market, which is actually something that came out of an FTC study. Kevin Singal did this in airline markets. They looked again at prices in airline markets where mergers occurred, how those prices changed relative to prices in airline markets where mergers did not occur. And that is the basic methodology.

The second strand I call the price equation approach. You look at price. Price is supposed to be a function of all these kinds of variables that affect price in addition to the merger and -- we'll go through those in a moment -- and you try to hold constant with that. One particular study is an FTC study done here by Schumann, et al., Larry Schumann, it's published as an FTC working paper in about '92, and appeared in, I think, the Journal of Regulatory Economics in '97, a piece of that.

Our analysis builds on those two methodological

approaches, and actually, I guess, makes a methodological contribution in that sense as well.

Okay, the transaction itself. As I said, we looked at a merger in Santa Cruz, California. It took place in March of 1990 and involved Dominican Santa Cruz hospital, which is a nonprofit hospital run by a Catholic charity group, and they actually purchased the only other hospital in the city of Santa Cruz itself, AMI Community Hospital, which was a for-profit entity. And I think there's actually people on the panel and in the audience that can tell you a lot more details about that than I ever can.

In August of 1990, AMI Community was converted into a skilled nursing rehabilitation facility. So, the hospital ceased to exist at that point as an acute care facility. And just in looking at that, the two hospitals, Dominican Santa Cruz and AMI Community, they're both located, again, as I said, in the city of Santa Cruz. They are about two miles apart. The only other hospital in Santa Cruz County was Wattsonville Community Hospital, which was located in Wattsonville, which is about 14 miles south of the city of Santa Cruz. And Santa Cruz itself is a fairly isolated area. It's about 40 miles south of San Jose, some 80 miles south of San Francisco. It's bordered on the south and

west by the Pacific Ocean, on the north and east by the Santa Cruz mountains.

So, basically, it was a pretty isolated market, and patient flow data that is discussed in the -- or on the matter suggests, again, that patients viewed it that way as well. About 94 percent of the three hospitals in Santa Cruz County, about 94 percent of their patients came from or were residents of Santa Cruz County and about 97 percent of the people in Santa Cruz hospital that used that hospital used one of these three hospitals.

Basically, so there were basically three hospitals in the county. The merger reduced the number of hospitals from three to two. The market share of the merged entity increased from about 62 percent to 76 percent, and the increase in concentration, the HHI increased from about 4,000 to over 6,000. So, a fairly high increase in concentration here.

As we see, in March 1993, the FTC accepts a consent agreement with Dominican Health Care. You're going to say, wait a minute, wait a minute, didn't Sacher just say, you know, there's no anticompetitive mergers out there. The FTC looks at those prospectively, and, you know, kind of blocks them from ever occurring. And here's something he's going to

talk about, you know, maybe being anticompetitive. Three years later, after it occurs, the FTC is accepting a consent.

Basically what happened here is that this particular merger did not meet the filing threshold, so it was allowed to consummate without a prospective review, and it was only in response to investigation on the part of the FTC that this merger was uncovered and investigated and basically the investigation didn't take place until it was already consummated and one of the facilities had already been converted to a skilled nursing facility, had already been changed over from an acute care facility.

The FTC accepted the consent, but this consent didn't break apart the merger. It just basically said, Dominican, if you're going to acquire anymore hospitals in Santa Cruz County, you're going to have to get our approval first. You're going to have to file with us first.

So, and what was the FTC's reasoning? Well, if you read the opinion surrounding this matter, all five commissioners said, we think this transaction has really created significant market power. But three of them said, well, it's already been consummated, there's not much that we can really do. It's going to take us

years to go through administrative litigation. Two commissioners actually said let's go ahead and do something. But three said we really can't. And another reason they said we can't is because Sutter Health had actually already had indicated that it was going to enter the market with some kind of health care facility, and they felt that this entry would at least restore the pre-merger status quo more quickly than administrative litigation ever could.

And as it did happened in the second quarter of 1996, Sutter Health opened a small maternity and surgery center with about 21 beds.

So, maybe bad for Santa Cruz County, but great for economists. This is really a wonderful opportunity to study the effects of the merger -- an actually consummated merger -- a very high increase in concentration, a fairly isolated market, and really there's actually very good data out there. California compiles very good data on its hospitals, which is why you always see a disproportionate number of health care studies taking place in California. It's because their data is so great.

And also, there were a number of years after the transaction for us to look at. We definitely looked at a number of potential candidates, and one

reason this one was, you know, as Lawrence said, you've got to give time for the contracting to go through and the cost savings to go through. Well, we were looking at this some six years, seven years, eight years after the transaction had already been consummated.

Okay, measure of price, we looked at, private patient prices. You know, it was private payor prices. It was net prices, it wasn't charges, from the California OSHPD office of state-wide health plan development data. We had about 10 years of data, they provided us with a load of diskettes, in view of being the government, we didn't have to pay for any of that, it was absolutely fabulous.

And then basically the methodology that we used was, we just kind of took going through more complex ways of looking at it to kind of test this hypothesis, did the merger result in increased prices? We looked at it in terms of prices per admission and per diem prices.

What we did first, we just looked at the behavior prices over time, and here's a graph just replicated from our paper, just looked at the behavior prices over time. We've got on the top the revenue per admission and the revenue per day. So, it's basically the first, and the dotted line indicates when the

merger took place.

Basically this is something of an upward trend there. You know, I remember when I was looking at this, I wasn't that impressed with it the first time I saw it, certainly an upward trend, but obviously this is not enough, this is just the first step in that. This is Dominican, and this is Wattsonville, again.

So, then we took the next step. We used a statistical technique, but it was kind of like musical regression, in which you try to look at the thing you're trying to explain as a function of all these other kinds of factors. And the first thing we did is a very simple specification, as we call it. We just looked at the price over time at the merging hospitals, and also looked at the price at the other hospital in town, in Santa Cruz. So, no, we didn't have to define the geographic market, we were just going to look at the competitive effects themselves.

And we looked at, A, the merging hospital, and B, we also looked at the competitor, the idea that maybe there was collusion going on, which is a hot topic again here at the Commission. Or it could also be explained by the unilateral effects theory, the idea that one person increases price in the same market, that kind of releases the constraints on the other one,

they can also raise prices.

So, we looked again at Dominican and Wattsonville. And both of these, again, were nonprofit entities, Dominican being a religious nonprofit entity, Wattsonville being a community-based hospital, and again, the paper by Lynk that I referred to, kind of in his paper, he actually argues that it is this kind of hospital that is least likely to -- least prone to exercise market power, given this it's community-based nature, that it's really about kind of a consumer cooperative. It never should raise prices, so it really is a good opportunity to test that hypothesis.

And a very simple specification, basically we just looked at, we had a variable to controlling for when the merger happened, and we had just something we call time, which is kind of just controlling for a general trend. We saw an upward trend, just trying to see if there was any kind of general trend there. And this very simple regression and I would suggest very substantial price increases, which were also statistically very significant. They basically were $700 for Dominican, about $1,800 for Wattsonville. Clearly this is a not good enough, this is just the next step that kind of gave us more confidence that maybe we're onto something here, but at least let's

take a closer look.

The next step, we kind of used the approach that I referred to as the price equation approach before the Schumann, et al. Approach used in evaluating some other mergers in some other industries in '92 FTC working paper. And it's based on the very simple economic idea that demand is equal to supply, or that price is both a function of demand and supply. And for that what you could do is kind of get this equation. This equation you have price and you look at all these other factors that affect demand, income, population, other factors that affect supply, input prices, et cetera, et cetera. And the merger itself.

And that was our next specification. So, again, here we used a lot of variables. We put out a considerable number of variables to try to control for all these other things that affect the price besides the merger. And I think we put in an extremely large amount of variables. If the paper was called Sacher and Vita instead of Sacher and Vita, there probably would have been fewer variables, actually, but that's the way it happens.

Case mix, again, one thing that could be changing over time is that the hospital could be treating increasingly more complex cases. We tried to

control for that with two variables. One we called case mix. Whenever you come into the hospital, you're assigned a DRG, is something used by Medicare to kind of classify patients. And Medicare also gives to each DRG a case weight index, so, let's say if you come with pneumonia, pneumonia you might get a case weight index of one. If you come in with cancer, you might get a case weight index of two, the idea being that the resource intensity use is twice as high for the cancer patient than it is for the pneumonia patient. And basically, we looked at a weighted average over time for each of the hospitals of this case mix index. We looked at average length of stay, the idea again here being for longer stays, that, you know, are more intense kinds of -- more costly kinds of procedures, that it's just another way of controlling for the intensity of care over time.

We had a bunch of variables controlling for input price changes, basically, again, things like medical equipment costs. I think we used some PPIs. We had a wage index, actually HCFA, whatever they're called now -- is it still called HCFA? For every locality for purposes of Medicare reimbursement puts together a wage index. We use that as a way of controlling for change, possible changes in wages of

hospital staff over time.

And also, one of my favorites here, the earthquake dummy. What is that? Well, actually, around the middle of '89, there was the Northridge earthquake, which could have had a very serious impact on Wattsonville's ability to provide care. So, we basically had to control for that. And we paid very close attention to this variable, because it's actually over -- when the earthquake occurred was not too distant from when the actual merger occurred, so it can actually confound some of what we're trying to measure there. And we played around for that, and I think we controlled for it pretty well. But as a sidelight, going beyond econometrics, we also argued that we kind of looked at Wattsonville's patient load over time and actually found that it had increased over time. And so that kind of suggests that the earthquake really didn't have that strong of an effect.

Other variables that we used: We tried to control for managed care variables, we tried to control for income over time, we had variables controlling for income, and we tried to control it for population density. I'm just trying to go to the demand side. We had variables again for various things that could affect demand, income, managed care, penetration

variables, which again were somewhat complicated, but I won't go into the econometrics of that. Population density.

The share of admissions covered by Medicare and MediCal, although we are looking at private-pay patients. There's literature out there that suggests there's cost shifting. The more Medicare/MediCal patients you have, the higher might be the prices for the private pay patients. We also had a variable for the entry of Sutter Health when that occurred. You would expect that to have an effect on prices as well.

Basically we use this more complex specification and we continue to find pretty dramatic price increases. We basically found a price increase of about $750 for Dominican and about a $500 price increase for Wattsonville. That was the next most complicated approach.

We then took another even more complicated approach and basically what we did there, what we said, maybe we haven't controlled for all these kinds ever variables that can affect price, so we used this methodology which I talked about which I called the relative price approach, where you just look at prices in other markets, and those prices in other markets that should be affected by some of the same demand as

supply conditions, and also used those prices as a control variable.

So, in addition to all these various cost and demand variables that we had entered, we also constructed a peer group of California hospitals. We used some peer group studies that have been done for the MediCal system, and we looked at hospitals that were in similar situations to the hospitals in the Santa Cruz County, and entered each of these control variables for those hospitals as well as an additional way of controlling that. So, we had a case -- we had, you know, prices in the particular counties, we also looked at prices in the other counties and used it as a control. And we continued -- and I think we continued to find that, again, there were price increases. We found that price increases were about $1,000 in Dominican, which is about 20 percent higher after the merger, and for the merger, about $600 to $700 higher at Wattsonville, which is about a 15 percent price increase.

So, again, I think we went through this in four different ways, and we found that clearly something happened in the wake of the merger that increased prices. We controlled for all these other things that affect price, and yet the merger variable showed a very

strong impact on price, a very strong positive impact on price of the merger. And so clearly there's something going on around the time of the merger to increase price, and that that thing that increased price was the merger. It wasn't any of these other variables.

Now, the question becomes, what led to increased price? Was it market power or was it something else? And I think we argue that the most compelling explanation is that it was market power. First of all, there were about four different things we did to substantiate that. First, we noted that in the record that was established here, the parties made no arguments related to quality. They said that the efficiencies that are going to result in this merger were really going to be economies of scale. The hospital AMI community was too small, they were going to reduce costs by merging it. So, it's not the kinds of efficiencies that should lead to increased prices; those are the kinds of efficiencies that should lead to decreased prices.

Another possible explanation is that now you've got higher volume and there's a lot of literature out there that indicates when a hospital has higher volume, that can lead them to increased quality. You can

increase your quality. So that that increased quality leads to increased prices.

And we would argue no, that because maybe you would allow Dominican to increase prices, but then why was Wattsonville able to increase prices? That's really not consistent with the market power hypothesis. In fact, Wattsonville price should have lowered its prices then in order to do that. And then you can argue, well, maybe Wattsonville had to increase its prices to keep up with Community, but then again, that doesn't really make sense either, because you shouldn't see a price increase as a result of that, because basically those kinds of price increases are not related to cost increases. Okay, and that explanation we didn't find too compelling.

Well, again, a third argument is that maybe there was some kind of expenditures that they were now able to undertake. Maybe they're able to open up these new wings that would increase quality, that are also more expensive, and we looked at that hypothesis. And what we did there is we looked at expenditures over time. And we tried to control for expenditures. And we found that, yes, expenditures did go up, but not nearly as much as prices went up.

So, maybe there was, we can't entirely rule out

that maybe they undertook some new expenditures that maybe increased quality a little bit, but it still doesn't go to fully explain what happened there.

And then, like Jim suggested, we actually looked at patient flow data over time. If quality was increasing, we would expect that perhaps more of Santa Cruz patients would be using the Santa Cruz hospitals, or that they wouldn't be leaving the county for them. We found exactly the opposite to be the case. We found that over time, after the merger, actually fewer Santa Cruz patients were using the Santa Cruz hospitals than before the merger. Again, something inconsistent with this quality-increasing hypothesis.

So, again, prices seemed to have gone up, we have very strong evidence of that, and all the evidence we looked at suggested very strongly that it was related to the exercise of market power. Again, these were nonprofit entities. Again, it was a fairly isolated market. But I think the moral lesson here is that post-merger conduct can be successfully evaluated, and that looking at consummated mergers, as I think was already pointed out, presents opportunities not necessarily available in the normal prospective analysis. You can evaluate the price changes, you can evaluate the quality and cost-saving claims, and you

can also look at changes in patient flow data in a dynamic context.

It's always talked about, you know, Elzinga-Hogarty is static, we can't use it. Well, here's your perfect opportunity to turn it away from that static kind of analysis to a more dynamic analysis. And we did some of that and there's actually a working paper that was kind of a complement to our piece by John Simpson. He took a close look at some patient flows and that's another thing that you might want to do as part of the merger retrospective project here.

And I will turn over to the next speaker.

(Applause.)

MR. ARGUE: While Sarah is getting that set up, I'm number nine, so I'm the clean-up hitter here. Usually the clean-up hitter is number four, I know, but I'll do that as number nine.

It's been a long afternoon, I thank you for your patience. I'm apologizing in advance that I don't have Lawrence's late-night humor, and I don't have Seth's peppiness, and actually, my subject is even less interesting.

(Laughter.)

MR. ARGUE: I'm going to be talking about some

of the problems and the difficulties that go into this economic analysis of prices in post-merger conduct. And while it may not be as catchy as all the others, I think it's an exceedingly important topic.

Chairman Muris stated in the fall, if I can paraphrase him a little bit, with regard to the merger review panel and the retrospectives and so forth that one of the stated purposes was to get some real-world information that may bolster the Commission's position and help it plan or develop new strategies for trying cases. Other FTC officials have talked in terms of a new paradigm for merger enforcement in health care. In short, the retrospectives really are, let's go back and take a look at what's happened and see if there are differences in price and differences in quality that might be attributable to market power.

And I would like to, as I said, address some of what I see are the conceptual challenges and the practical challenges for doing this. And I think I'm alone among the attorneys and the economists here to say that I don't think that this is necessarily a great project that the FTC has embarked upon.

I think it should be undertaken with considerable restraint, and the results should be interpreted very carefully. And I think as I go

through the next 20 minutes, you may understand the basis for my thinking on that.

I would like to start off with it's just a reiteration of points that I have made elsewhere about some of the fundamental places we have to start in making these analyses. They have to be consistent theories. I beg the pardon of anybody who has heard this before. It will only take me a minute to go through these, but I think based in part on some of the things that were said today, that it's useful to go back and remind ourselves the necessity of having good theories.

Any of these analyses needs to start off with a theory that's internally consistent and that has a causal link, that connects the merger and the alleged -- or the expected post-merger behavior. This is not a formality, it's not something that can be easily dispensed with. It's an important and integral part of disciplining the thinking and disciplining the data collection.

The theory must also be consistent with the underlying assumptions of economic theory about how firms behave. And we've had some discussions about for-profit and nonprofit, but setting that aside, one of the principles in the merger guidelines is if a firm

has market power, they'll exercise it. And that's what we ought to be looking for.

The theory must be consistent as to the sources of market power. Is it a unilateral effects theory that's causing the event that's causing this or is it a collusive coordinated behavior?

The theory also needs to be consistent in the ways in which market power would be exercised. For example, a theory that does not describe price discrimination should not predict that market power will be exercised only against some of the consumers. Or if the theory predicts that inpatient prices would increase, only inpatient prices, then an observation that outpatient prices is increasing is not helpful. It's not confirmatory evidence.

And the theory also needs to describe a mechanism by which the prices would increase. If the hospital allegedly has market power in all of its services, then the theory needs to explain how all of those services are going to have an increase in price. Or if it's only in some of the services, say it's just inpatient services, we would expect the theory to be able to explain why it's some inpatient services that are rising in price, but not the outpatient services.

That's just what I see as some discipline that

the analysts and researchers need to impose upon themselves as they go through this process.

Now, let me turn to the main part of my comments. And that's just what are some of these practical difficulties? There's been a lot of discussion today about how we can go through and measure these effects, and I find that it's -- that a lot of the problems were glossed over. There are many issues that are related to it, and I have just identified them in summary fashion here. There's availability of appropriate data, there's the heterogeneity of hospital services, changes in input costs, differences in quality, and a few other factors. And I'm sure there are others that I haven't thought of that would be appropriate to add to this.

Before I address what I see are the problems, I want to lay out what I think are the two main ways of going about this type of analysis. And Lawrence identified a third one that I will talk about a little bit as well.

Both of these strengths -- both of these approaches have strengths and they have weaknesses, and it's not clear that using them in tandem is sufficient to get a true picture of the price changes. That is, the strengths of one don't necessarily offset the

weaknesses of the other.

These two approaches are what I'm characterizing as an average payment approach or an average revenue approach. It's done typically on a per case basis or on a per diem basis. This was the approach that Seth just described was done in Vita and Sacher. And as an aside, I don't intend to critique the Vita and Sacher paper in any detail, but I will note in my comments where I see that some of the issues that I'm raising have come up in their paper and how they have addressed it or not addressed it.

Seth said that his paper was really a roadmap to ideal analysis and I just want to point out a few potholes along the way. Hopefully not any blind turns, but we'll see about that.

An analysis of average payments is typically based on the hospital payments data. It could also be based on the payer's claim data, the information that you would get from a managed care company. And this approach boils down to something simple. You just take the revenue or you take the payments and divide it through whatever you want. Whether it's cases or days or what have you.

The other approach, and it hasn't, I don't think, been discussed here today, is a comparison of

contracts. It's commonly done, and it suffers from -- it doesn't have some of the problems that the average payments approach does, but it has some other difficulties.

This approach is methodologically quite different from the average payment approach. It involves an analysis of negotiated terms of contracts. Typically, the basic approach is to compare discounts off charges or the case rates or the per diems or what have you, or sometimes all of the above. They can be a mix of things in the contract. And the contract terms are independent of the patient mix, and it's in that sense that maybe, maybe that's a little bit closer to being the price.

The third approach that Lawrence referenced was the simulation approach, and I have in my mind what I think he's talking about, and I'm not sure if it's right, but it's, I think, trying to overlay actual patient results or information on different contract terms. That's a complicated and difficult thing to do. Conceptually, it sounds great, but I think that it has some of the same difficulties that I've outlined here, plus some others.

Let me go on to these four or five points that I mentioned before. And the first one is the

availability of data. Starting off with the average payments approach, one of the challenges with the average payment approach is that hospital records often have insufficient detail to perform an average payment calculation. Lawrence made a reference to this and Jim did as well. I haven't talked with Seth about it, but I think he may disagree with that.

Many hospital records have information on charges incurred by an individual patient, but not on the revenue actually received by the hospital for that individual patient. The issue comes down to how do hospitals account for the contractual allowances? They are often taken out at the hospital level, not at the patient level. So, you may find gross charges for patients, but you may not be able to find the net payment for an individual patient.

Sometimes these contractual allowances are mixed, the inpatient and the outpatient are together, and all of that is lumped together at the hospital level, and that complicates it even further.

Now, this problem was addressed in Vita and Sacher. They ran into the problem, and they resolved it by using a ratio of inpatient gross charges to total charges as a way of allocating the net revenue. This may seem like a sensible assumption on the surface. I

don't think that there's any particular reason to believe that it gives you the right number. But it is identifying the problem and making an attempt to resolve it.

Another complication in this type of analysis is the fundamentally different types of contracts which are capitated. There you're getting a payment that has nothing to do with the service, it's just a payment. And that needs to be handled as well.

The second type of comparison is with the claims data. And though they don't have all of the same problems as the hospital data, they're different issues that come up here. Insurance claims data typically have a large number of adjustments to the data, to the claims, not all of which are easily distinguished in the data. There are reversal, there are denials of claims and assorted other things.

There also are different types of services: Inpatient, outpatient, physician services, ancillary services. Sometimes these are collected all together and end up in one single payment to the hospital. And harkening back to the conceptual issues, and this, again, is something I think it was Lawrence who raised it, that you may need to go -- you probably do need to go back and look at all of the insurance companies'

information and not just a single company or two companies. Because unless you've got a price discrimination story, the theory is going to tell you that prices should go up for all of the payors. So, finding it for only one and not the others is not going to be adequate.

I think I'm getting ahead of myself there.

The second approach here is the contract comparison approach. The contracts, one of the biggest issues with the contracts is that they contain many nonprice terms that need to be taken into account that are relevant to the negotiation, that are relevant to the final price that comes out. These include things like the duration of the contract, whether there's any exclusivity, discounts or penalties related to early payment, or late payment, rates on and inclusion of other services, ancillary services, lab services and so forth, and sometimes the rates for Medicare and Medicaid managed products. They are periodically negotiated together, you get a better rate on the Medicare, you end up with a worse rate on the commercial, or vice versa.

Moreover, there's typically a variety of prices or a variety of types of contracts in a market, and that makes comparisons of contracts very difficult.

The hospitals in the same market often have different contracts, that can be discounted fee for service, case rate contracts, per diem contracts, certainly capitated contracts and others. There are carve-outs for specific services so you can have a mix of types of contracts all rolled in one.

And it's very difficult to convert these contracts to a standard basis. And then make a comparison that would allow you to do -- to use some contracts over time, or to have a comparison between hospitals.

Now, going on to the second point that I had, was the heterogeneity of services, and again, that's a point that's come up a few times or this afternoon.

It's patently obvious that hospitals had heterogenous services, a variety of services that they provide. And it makes it difficult to compare prices in a meaningful way. That is a problem that's common to both the average revenue or the average payments approach as well as the contract comparison approach.

If you're doing, for example, an average charge or an average payments approach, you can get a difference in average payments that's got nothing to do with the prices when it's just a change in the mix, or a change in the intensity of the services being

provided. That all needs to be controlled for in order to get an appropriate comparison.

And likewise for the contract comparisons, there are clusters of services that may be covered under one specific rate for one hospital, and it's a different cluster for another hospital, or a different cluster for the same hospital in another time period.

What are some of the sources of heterogeneity? I'm not sure if you're going to be surprised of these, I'll just go through some of these quickly. The services offered by one hospital are very often different than the services offered by the next hospital right down the street. Despite Kirby's comments that Divine and Williamsport were clones, my bet is if you look at it carefully, there were some differences in the services provided.

Moreover, the services actually received by one patient are typically different from the services received by another. And these services change over time. And they change at different rates, and consumers have different perceptions of quality between hospitals and over time.

The courts have often grouped services in a cluster for antitrust analysis, and there are some practical reasons for why that might be helpful, but it

doesn't fundamentally change the fact that individual services generally are not demand-side substitutes.

One way to address this heterogeneity or sometimes is used to address the heterogeneity is to try to subset the services into small enough groups so that you are actually looking at like services, homogenous ones. In reality, it's really quite difficult to do that. Even within apparently homogenous services, there tends to be significant variability.

DRGs and CPTs and ICD-9s, they all sound homogenous, and at one level they are, but only in a broad sense. Or something like cardiac catheretization or cardiac surgery or newborns. Those sound homogenous, and in a broad sense they are, but if you look at them more carefully, there's a lot of difference in the level of the service actually received by patients, depending on acuity, duration of stay, physician practice style, many of these things are very difficult to control for.

And these variations can cloak actually what's happening with the prices underneath.

The next item on the -- on my challenges list is input costs. It's no secret that there are some major sources of change in costs for providing hospital

care, including nursing staff. Nursing shortages seem to come and go. We're in one now and it's driving up the wages of the nurses.

Pharmaceutical costs have risen dramatically, and the costs of the hospital have changed as well. Both because of the rising drug prices, but also because of utilization. And the same thing goes for high-tech supplies.

Insurance costs, malpractice insurance costs are considerably -- change significantly as well.

There have been a number of numerous attempts to address these types of issues, either explicitly by including some of these factors explicitly in an estimation, or by trying to control through some peer group comparison. In Vita and Sacher, I think, attempted to use both of these. Seth, I apologize if I'm getting parts of your article wrong, but I'm sure you can correct me on that.

The peer group of hospitals that Vita and Sacher used was based, I believe it was based on fairly limited criteria related to the size of the beds and some other elements, but that's not clear to me that that was adequate for controlling for those differences that they are trying to control for. And my recollection is that they also tried to track some of

the intratemporal changes by including some cost elements in their equations.

And then finally, almost finally, we get to differences in quality. This is a tough nut. Everybody knows that it is. It's widely acknowledged by the agencies, by attorneys, by the economists, that for proper price comparisons, we have to be able to control for differences in quality. Both between hospitals and over time. And quite frankly, there are no good measures that are well established for this type of analysis.

The agencies have suggested some approaches for addressing quality that I think fall far short of what have's needed. They talk about, again, this comparison of hospitals within control groups, or simply asking the hospitals. Tell us specifically what the detail -- in detail what the nature of your quality improvements have been. I don't see that those are going to be adequate to address that issue.

There's one other factor that's not on the slide that I think that needs to be brought in, and there probably are a whole bunch of them that are not on these slides, but one that comes to my mind is the extent of cost shifting can change over time. The balanced budget act of 19 -- or amendments in 1997

illustrated that clearly, that the hospitals were really in a bind, and that account affects the prices that they charge, because there's a much greater need for cost shifting to cover the Medicare costs over that time period.

So, let me wrap up. It's a fair question to ask, well, now that you've dumped on all of this, what alternatives are available? And I haven't seen an approach that I think is without significant shortcomings. There may, however, be some guidelines that are -- that an appropriate alternative must take into account. And these are not organized in any real tight way, but some thoughts that I had on this.

One is that the approach has got to be consistent with the positive theory. Secondly, it needs to recognize that hospital services are fundamentally and inherently heterogenous. In calculating costs -- in calculating price estimations, it's going to be helpful to make these -- make these estimates as robust as possible by using broad samples, large numbers of observations.

And there ought to be a recognition, clear recognition that there's going to be a lot of noise in the results that come out of here. And that small price changes should be considered with considerable or

should be viewed with considerable skepticism. It's too strong a statement to say that appropriate price comparisons can never be made, but there are many assumptions that are likely to be necessary. And all comparisons need to be viewed in light of the weaknesses of the methodology and the limitations of the data.

As I said at the beginning, the retrospectives should be undertaken with considerable restraint. They're costly to the hospitals and there's little assurance that they will actually yield accurate results.

Thanks very much.

(Applause.)

MR. MARTIN: As moderators, John and I have had the heavy obligations of assuring that there are adequate bathroom breaks, and to ensure that the discussion at this point in the program is controversial. We think we've done the former, and for the latter, we thought we could do it easily by asking Bill Kopit if he wanted to comment on anything any presenter from White & Case had said during the presentation. But we're not going to take the easy way out. We're going to hold that question, and instead take the hard way, and then come back to Bill later.

So, John?

MR. WIEGAND: I first wanted to ask Seth Sacher if he had any response to David's comments on the Santa Cruz study.

MR. SACHER: Sure. I mean, you can always, you know, say things like, well, you should control for private payors, Vita and Sacher did that, but it could have done it better. You should control for case mix over time and changes in demand and cost. Well, you know, Vita and Sacher did that, but they could have done it better.

You know, I think we did a very good job on our paper. I'm glad you read that really involved footnote about how we derived the private pay prices. I thought nobody would actually read that footnote, and I wish I could blame that on Mike, but actually I'm to blame for that footnote.

But yes, there's always going to be these kind of criticisms for econometrics. I think it's a lesson, I mean, the FTC holds these hearings and they can learn the kinds of things that they might hear in the court situation. And you know, I wouldn't advocate that this is the only input that you should be using in your review of mergers, it shouldn't just be econometric studies. It's very important input, it should give you

a great deal of confidence in looking at the market, but yeah, you've got to go out there and get all kinds of information.

You know, looking at patient flow, look at what people have said -- looking at these specific contracts that have been negotiated and taking all these kinds of criticisms into account and fully evaluating the merger before actually going out there and seeking to reverse any kind of transaction.

So, far be it for me to say -- I may have said that I answered all of Lawrence's, you know, how-to's, I was being a little facetious there. Clearly, there's always going to be possibilities of intense kind of criticisms in the nitty-gritty and I don't think that should hold the FTC back from its merger retrospective program.

MR. WIEGAND: I've got an issue that I wanted to raise maybe first with you, Seth, and then open it up to other members of the panel, about the nature of the methodology for examining post-merger prices. I think in your paper you looked at it on a quarterly basis, but the context here is a lot of times we have contracts that are long-term contracts that are in effect between the payors and the providers, and therefore the impact of the mergers may not be felt for

several years out. And then Bill said, on the other hand, that, you know, government should not necessarily be held to show an increase in price, even in post-merger context.

So, you know, maybe Seth, you would like to respond a little bit on the extent to which you should be using quarters in looking at the first few quarters out and then other people can comment.

MR. SACHER: That was one thing that we had considered in the paper early on, to have this annual kind of contracting, or maybe even more than that. We think that it's really not relevant what the payors are doing every year, it's relevant what the hospitals are facing, that they're facing these kind of price changes continuously throughout the year.

And getting back to econometrics, we did experience, with some kind of lag, things and then to try to prepare for these kinds of criticisms, didn't find those being particularly important to the works.

So, you know, we consider that, and I would also point out that the complementary piece that I talked about by John Simpson in the Bureau of Economics doesn't look at quarterly data, it looks at annual data, relooks at this transaction using a different methodology, also finds significant price increases

quite on the order of what we found. And also, again, he looked in detail at the patient flow story and found a very sensible way in that some of the closer-in zip codes, there was not much loss of patients, some of the further out ones there was a greater loss. But I look at it in the context of critical loss, finding that actually, you know, even though it was greater in the more outlying zip codes, it was still below the standard kind of critical loss that people might look at.

I'll turn it over to the rest.

MR. WIEGAND: Does anyone else want to talk a little about whether we should be looking further out for price increases?

MR. WU: Yes, I think we ought to be looking fairly further out, and to comment on some of the issues that Seth just raised, I'm not sure it's appropriate to look at quarterly data or annual data, because I think what the analysis really deserves is a careful look at the contracts, because a lot of times the contracts that one -- that hospital would receive reimbursement for, in one year, is really negotiated the prior year. So, a lot of times, say in the year right after the merger, a lot of the revenues associated that would be observed in the year right

after the merger or maybe a couple of years after the merger, are from contracts negotiated before the merger. And that's why I think one really actually does have to be careful in making sure that one accounts for the contracts and when those contracts are signed.

And looking further out, one would be more confident that most of the reimbursement is -- can be attributed to contracts signed post-merger, than the first couple of years after a merger that's not so clear. And again, that goes to the length of the contracts and, you know, what is known when the contracts are signed.

MR. KOPIT: I would agree that the length of contracts is important, and you have to look at contracts, or you should look at contracts, but I think you said you were looking at six years.

MR. SACHER: Yeah, I think we had a pretty --

MR. KOPIT: And six, I don't know of most -- contracts don't last six years. I mean, one year, two years, three years, maximum, usually. So, if you have six years, I think you've probably covered it. You know, unless there's strange things going on from quarter to quarter.

What I said about the notion of what the FTC

would have to prove, and I guess David Balto disagreed with that, too, although I don't think the only thing he disagreed with that doesn't have anything to do with Grand Rapids. No, I'm sorry.

MR. MARTIN: Don't go there.

MR. KOPIT: I think that if the FTC -- I'm not suggesting that the FTC shouldn't use price information, I think they should. I think the one single thing that you have available in a retrospective that you wouldn't have by definition in a prospective is price information, what actually happened. And that should be very important, and I think you can get it from payors in a usable fashion most of the time, not without difficulty.

But what I was saying is as a matter of law, if the FTC can show, for example, that you've got by looking at market definition. And by the way, we didn't talk very much -- one thing that I didn't get into in my talk that I wanted to at least mention, when I was talking about correcting things that the courts had done incorrectly, I was talking almost exclusively about geographic market definition, which I mean, I just --it's inconceivable to me how badly it's been done, and I would hope that the FTC can do a much better job of it. It can't do a worse job of it.

And -- but I mean, I think that's really fertile ground for coming up with something that makes more common sense and is logical than what some of the courts have done.

But, my point was, if the FTC can define a market and show the existence of market power in that market, that should be enough to switch the burden for the defendant to say, well, yeah, but I didn't exercise that market power and here's why.

MR. MARTIN: Well, why do you need to look at retrospectives in order to straighten out the case law in market definition?

MR. KOPIT: You don't.

MR. MARTIN: I mean, what I would like you to do is if you could argue on David Argue's points, which is -- and I think David Balto's to a point, which is that there's very little out there on the post-merger effects of any mergers in general, in terms of economic stuff. The data is difficult to come by. Courts won't have merger guidelines to rely upon. It seems like; isn't this a Herculean task to come up with on-the-fly standards by which to measure whether price increases post-merger were anticompetitive or not, and do all the rest of the other stuff? I mean, why would courts be anxious to buy into this?

MR. KOPIT: Well, I mean, the courts aren't going to do it. The economists are going to do it as experts, in testifying. Now, if you ask me a different question, which is would we be better off in courts if rather than having a plaintiff's expert and a defendant's expert, we had a court-appointed expert, the answer is yes to that question, but that ain't going to happen. So, the hope is that, you know, that if you have two experts, either through what they say, or through a combination of what they say and what comes out on cross examination, a Judge can make a determination and a distinction between which one is closer to reality. Because my guess is, in most cases, they're going to say different things. That may be a shock to you, Rich, but that's the way it comes out.

MR. MARTIN: But if I read -- if I read the cases correctly, I think most courts have listened to the experts and kind of said, I don't know, and come up with a market definition largely disregarding what the experts have had to say. So, why do we need more expert testimony on more imponderable questions, having done the data?

MR. KOPIT: I disagree with that. I think that -- I disagree that that's what the courts have done. I think the courts have accepted testimony from

experts that have defined markets in lots of cases that are way too large, that don't even make the smell test. I mean like Tenet was the worst one. I mean, 70 miles? Come on, get real. That's not happening.

I mean, and you could -- I mean, but there are others where you have these really extensive markets, but those markets have been testified to by experts. I'm just thinking that if that -- if that process where you have the plaintiffs -- if you have the FTC's expert testifying that really the market is somewhat smaller, and you have the defendant's expert saying, oh, no, it goes that far, there's a more likelihood that the FTC, not just because of the home court advantage, but because you have more sophisticated people, and people that understand more about antitrust, you're more likely to get to a market definition and a market definition process with the use of different elements in determining that, you know, that that's closer to reality. That's all.

MR. MARTIN: So, a lot of this is contingent upon the FTC doing it through the administrative process?

MR. KOPIT: That was my point.

MR. MARTIN: Yeah, okay.

MR. WU: Usually I love to talk about how the

district court did get it right in Tenet, but I'm not going to talk about that. But see, there is an issue, though, that's raised that goes back to the methodology which is the original question. Now, suppose it were true that we really did have to look six years after a merger to reidentify the price effect of the merger. It seems to me that has implications for the value of a retrospective review. It's more Unlikely to unscramble the egg after two years, yet at the same time, what I'm hearing is that it's very likely that we may be able to discern the effect after two years, because I think there's a little tension here between methodology and identifying effect and practicalities of a remedy and an investigation may be out of context.

MR. SACHER: We have very good evidence that you only negotiate contracts every 15 years then maybe you have a good criticism or study. I mean, certainly you have to go out there in the field and ask about contracting practices is a compliment to that kind of thing.

MR. KOPIT: Lawrence, I do think that the district court got it right in Tenet. It was the court of appeals that got it wrong, didn't they?

But, the one thing I would disagree with is I don't think that if something goes on more than two

years you're necessarily talking about a situation where you can't unscramble the eggs. I mean, sure, in some cases that's true. In some cases you can't unscramble the eggs after a year.

But there are situations out there where hospitals have done nothing over long periods of time to change, you know, their clinical services. And that's what I think I said were the areas where unscrambling is a problem. In situations where there's been considerable clinical consolidation, I don't think unscrambling is a remedy you should get or even ask for.

MR. WIEGAND: Undoubtedly, though, there is tension between the desire to get better data, which means go later, and the desire to get a more effective remedy, which means move sooner.

MR. KOPIT: Well, yes, but, I mean, where that leads you to is no retrospector at all. You continue to do what you were doing, which is going before the fact, and stop it right before it happens, because if you say, Well, we're not going to do that, but we're going to go in after a year, but we really don't know anything after a year. I mean, what's the point?

MR. WIEGAND: Well, I'm just suggesting that if you're going after the fact, you need to balance those

two.

As far as a point that Lawrence made earlier about improvements in quality generally being associated with increases in price, I was wondering if there is any evidence to support this and, maybe, there's a possibility that improvements in quality actually lower costs, because if you have better quality of care, you stay less acutely set and are in there for a shorter period of time for a need for high-level services.

Can you comment on that, Lawrence, and maybe other people can say something about that?

MR. WU: I mean, quality is a very tough issue, and I'm sure that will be part of the issues that you discuss later when you talk about quality.

But, again, I think -- I'm not sure what to say about this except that, you know, you need to be careful about how we evaluate quality. If it's in terms of costs, then that has some vindications about how we expect to see it showing up in terms of price, but if it's one of those new services, then I would expect to see it in terms of higher prices.

So, again, I think this is just being careful about what quality improvements we're talking about and how payors view those improvements.

MR. ARGUE: I just have one comment, and I don't have the clinical expertise to know whether something like that occurs, but I suspect that there are quality improvements that actually do lower costs. So, by trying to measure by cost you may end up -- you may end up missing something. I don't know, on balance, whether they are more or less of those, but it's something to take into consideration.

MR. TAYLOR: Let me give you an example and follow up a little bit on this quality thing, because it happened very close to Duke Hospital. Duke Hospital is a world famous hospital. I mean, they're on the cover of Time Magazine and everything.

But, two months ago, Duke Hospital transplanted a wrong organ into a patient down there. Now, if you try to measure quality, Duke Hospital, all of a sudden it's in the toilet for one case in about the last 10 years and Duke Hospital is about a 1,400 bed hospital, and, so, the point I'm trying to make here is one of the things about quality is do you really damn the entire medical center for that one case at that one point in time, because one surgeon failed to confirm he had an A-negative organ and stuff like that?

And, so, I've tried to look at quality as it relates to efficiencies and things. And using Duke

Medical Center as an example, and, I don't know, like Lawrence and some of the others have said, it defies the discipline, I think, which really you need to have to put it in perspective.

MR. MARTIN: Bill, I'm going to put the burden on you now. We're going to ask you to comment on anything that David said, but it's your obligation, you take as much time as you want and you think the crowd will take, and then we'll finish.

MR. KOPIT: I'm going to tell a joke. David talking about Grand Rapids reminds me about the guy telling the story about when he was introduced at a dinner, where he said the guy gets up there and he says about me -- and you can tell it's an old joke by what comes next -- a guy gets up and he introduces me by saying, I want to introduce now a man that's made $2 million in the stock market -- and then he gets the guy's name -- and the guy gets up there and he says, Thank you very much for that very gracious introduction, but, unfortunately, it wasn't me, it was my brother; it wasn't $2 million, it was $4; and he didn't make it, he lost it.

(Group laughter.)

MR. KOPIT: And David talking about Grand Rapids is about the same thing. I mean, I must be at a

different meeting.

I guess all I can say, you know, within the limited time available to all of us, is (1) the FTC said at the time of the merger that these two hospitals were very low-priced hospitals. They used that in the context of saying that even if they raised prices 10 percent after the merger, it won't make any difference because nobody is going to these other hospitals because they're still more expensive.

So, you're talking about two hospitals that started off with the FTC conceding that they were low priced.

You, then, had these hospitals agreeing to freeze their prices for three years and to not raise their prices beyond three years by the cost of living in any year.

David said, if I didn't hear him wrong, that they did that. He said that it's going to change next year because the community commitment is off and I guess you can take a look at them then.

But, to date, they're, if anything, a lower-priced hospital then they were then, by a lot, because there prices were frozen for three years and then -- and by the way, they were less than cost of living on the out years -- so, there's that.

On the cost thing, you know, I honestly don't know -- and I have not looked at the numbers behind the efficiencies -- but I will say that the average cost per admission at those hospitals since the merger has gone up less than .5 percent a year, since the merger. That strikes me it was not a lot, okay?

I will also say, and you will find this to be consistent, that they went from being very profitable hospitals, before the merger, they were making -- I think Butterworth was like in 7 percent profit with a surplus, which is high -- Blodgett was making somewhat less than that, but maybe 5 or 6 -- they're now making, I think, 1.3 percent profit, okay, or surplus, which tells me something about the fact that they froze their prices. And even though their costs haven't increased very much at all, when you freeze your prices for, you know, almost seven years, you make less profit. But I don't think consumers are being hurt at all and I think at the moment they're getting a bargain, and, you know, we'll just have to play it out.

The last point that David said, as well, their HMO, Priority Health, increased the number of people that they have. By the way, they don't have anything near 50 percent, at least the numbers I get, but the answer is, yeah, Priority Health increased it's

enrollment and Priority Health has a 28 county service area. Priority Health deals with lots of other hospitals beyond Butterworth and Blodgett, so the notion that they increased their enrollment in a larger service area didn't have anything to do with Blodgett and Butterworth. It had to do with what they're doing -- and they're not doing any worse in the other areas than they're doing with Blodgett and Butterworth. That's point (1).

Point (2) is that part of the agreement was that Priority Health would not favor -- excuse me, that Blodgett and Butterworth would not favor Priority Health compared to any other managed care that was in existence there. So, everybody is -- other managed care plans are getting exactly what Priority Health is getting in terms of rates from Blodgett and Butterworth.

So, other than that, I guess I agree with David.

MR. MARTIN: Well, I have to say Bill that you sound like you're closer together now than you were two years ago. So, I think we're making progress.

MR. KOPIT: We're working on it.

MR. MARTIN: And in five years I think you ought to be embraced with each other on the view of this case.

MR. KOPIT: He said he was going to be balanced.

MR. MARTIN: Okay, we have to stop, because we said this would be over by 5:00, and we really made it, barely.

MR. WIEGAND: We'd like to conclude by thanking all of you for coming, thanking all our panelists for preparing and presenting today and discussing matters. The folks who planned this, Rich Martin and his colleagues at the Department of Justice, and David Hyman and Sarah Mathias and Cecile Kohrs here at the FTC. Have a great weekend, thank you.

(Whereupon, the workshop concluded for the day.)

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

DOCKET NO: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

TRIAL DATE: APRIL 11, 2003

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

DATED: MAY 6, 2003

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SALLY JO BOWLING

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

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

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SARA J. VANCE