[PUBLIC]

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: Deborah Platt Majoras, Chairman
Orson Swindle
Thomas B. Leary
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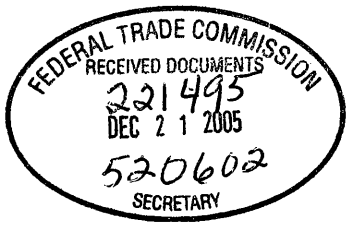
Jon Leibowitz



In the Matter of North Texas Specialty Physicians, a corporation.	Docket No. 9312

MOTION FOR STAY OF FINAL ORDER PENDING JUDICIAL REVIEW

TO: THE COMMISSION

Pursuant to Commission Rule of Practice 3.56, North Texas Specialty Physicians ("NTSP") respectfully files this Motion for Stay of the Final Order entered by the Commission against NTSP, dated November 29, 2005 and served December 7, 2005, pending judicial review by the United States Court of Appeals for the Fifth Circuit.

INTRODUCTION

On November 29, 2005, the Commission entered an opinion and Final Order (the "order") against NTSP, affirming in part the decision of the Administrative Law Judge, but imposing a more restrictive revised order. Section II of the order prevents NTSP from refusing to deal with any payor and, if NTSP continues to messenger contracts, requires NTSP to messenger all payor contracts. Section II also prohibits NTSP from communicating information regarding payors and contracts to its physicians. Section II's only exemptions are for financially or clinically integrated arrangements, as defined by the Commission. Sections IV.A and IV.D

require NTSP to provide notification of the order and the Commission's Complaint to numerous parties. Section IV.B requires NTSP to terminate all of its contracts (except for one risk contract) within one year of the effective date of the order or earlier. Section VI requires NTSP to allow the Commission access to its documents and employees without any apparent right to invoke attorney-client, physician-patient, or other privileges. The remainder of the order is ancillary to carrying out the provisions explained above.

NTSP believes the Commission's opinion has both misinterpreted the law and misapplied the law to the facts. Further, even if the Commission's decision was correct, NTSP believes the order is overly broad and not reasonably related to the Commission's findings. For these reasons, NTSP will file a petition for review of the Commission's opinion in the Fifth Circuit. The petition for review will address important legal questions on which NTSP has made a substantial showing of the merits. Further, the enforcement of the order now, if it is overturned by the Fifth Circuit, will irreparably harm NTSP, non-party physicians, patients, and health plans, and the public interest. The order requires that NTSP abandon its spillover business model and messenger all payor contracts; that NTSP not engage in appropriate communications with physicians, patients, and health plans; that provider contracts be terminated, regardless of the effects on non-party physicians, patients, and health plans; and that NTSP discontinue participation in lawful and potentially lawful activities. For these reasons, the Commission should stay its order pending judicial review.

ARGUMENT AND AUTHORITIES

I. A stay should be granted as to the entire order.

The entire order should be stayed. The Commission considers four factors in determining whether to grant a stay: the likelihood of success on appeal, irreparable injury to the appealing

party if the stay is not granted, injury to other parties if the stay is granted, and the public interest.[1] In this case, the Motion to Stay should be granted because, as discussed below, NTSP has made a substantial showing on the merits of difficult and important legal questions, NTSP and non-parties will suffer irreparable harm if the stay is not granted, there is no injury to other parties if the stay is granted, and the stay is in the public interest.

A. Likelihood of Success on Appeal

This factor weighs in favor of NTSP. The Commission has applied the likelihood of success on appeal factor broadly, holding that a stay may be appropriate when a case involves difficult legal questions or a complex factual record and the appealing party can make a substantial showing on the merits.[2] As the Commission has said, "it can scarcely be maintained that the Commission must harbor doubt about its decision in order to grant the stay."[3] The Commission has held also that the probability of success that must be demonstrated is inversely proportional to the amount of irreparable injury suffered absent the stay.[4] Similarly, the Fifth Circuit requires only a showing of a substantial case on the merits when a serious legal question is involved and the balance of equities supports a stay.[5]

This case involves both a complex factual record and difficult, serious legal questions on which NTSP can show a substantial case. The administrative hearing lasted more than two weeks; there was testimony from 17 witnesses, nearly 15,000 exhibits were admitted, and there

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[1] 16 C.F.R. § 3.56(c); *In the Matter of Novartis Corp.*, 128 F.T.C. 233, 233 (1999).

[2] *Novartis Corp.*, 128 F.T.C. at 234; *In the Matter of Toys "R" Us, Inc.*, 126 F.T.C. 695, 697 (1998).

[3] *Toys "R" Us*, 126 F.T.C. at 697 (quoting *In the Matter of Cal. Dental Ass'n*, Docket No. 9259, 1996 FTC LEXIS 277, at *9 (1996)).

[4] *Cal. Dental Ass'n*, 1996 FTC LEXIS 277 at *10.

[5] *United States v. Baylor Univ. Med. Ctr.*, 711 F.2d 38, 39 (5th Cir. 1983). The Second Circuit, which applies a similar standard, has explained the substantial showing requirement as being met even where the likelihood of prevailing is less than 50 percent. *Mohammed v. Reno*, 309 F.3d 95, 101-02 (2d Cir. 2002).

are almost 3,000 pages of hearing transcript. The ALJ's Initial Decision was 97 pages and contained 380 findings of fact. Among the legal questions that arose during the hearing and subsequent appeal to the Commission were (1) whether the Commission complied with the standard of analysis required by the Supreme Court in *California Dental* when NTSP proffered economic and business justifications for the behavior and Complaint Counsel eschewed proffering any data showing evidence of anticompetitive effects of the challenged behavior;[6] (2) the extent to which Complaint Counsel must define and prove a relevant market;[7] (3) whether there can be collusion when there is no evidence of an agreement between competitors or a common agent with binding authority;[8] (4) whether the *Colgate* right applies to an IPA entity whose refusals to deal with payors are not binding on its participating physicians and are based upon its own business model and reluctance to become a party to certain contracts;[9] (5) whether the only appropriate use of the messenger model requires an IPA entity to messenger all payor contracts;[10] and (6) whether the NTSP spillover model is a sufficient justification under *California Dental*.[11]

These issues are directly related to the provisions of the order that prohibit NTSP from refusing to deal with payors, prevent NTSP from pursuing its spillover business model, require termination of NTSP's current contracts, and prevent NTSP from communicating with

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[6] *E.g.*, Respondent's Appeal Brief, filed January 13, 2005 ("RAB") at 28-29, 35-36, 42.

[7] *E.g.*, RAB at 36-42.

[8] *E.g.*, RAB at 9-10, 12-14.

[9] *E.g.*, RAB at 14-17.

[10] The Commission held as much in its opinion—"the key to a lawful messenger model is that the IPA must be willing to messenger *all* payor offers"—but Complaint Counsel admitted during opening statements that the failure to messenger a contract, without more, is not an antitrust violation. *See* Opinion of the Commission at 26, 35 (emphasis added); Complaint Counsel's Opening Statement, Tr. at 60 (Exh. A).

[11] *E.g.*, RAB at 18-19.

physicians, patients, and health plans. As a result, the remainder of the order requiring NTSP to send notice and allow the Commission access to its records and employees is also implicated.

NTSP will not repeat in this motion all the arguments made in its briefs before the Commission, but those arguments alone make a substantial showing on the merits of the issues raised in this case.[12] Further, NTSP will make (more than) a substantial showing on the merits specific to Fifth Circuit review. Many of the issues that will be presented to the Fifth Circuit relate to the Commission's legal conclusions and application of the law to the facts and will be reviewed *de novo*.[13] Supporting NTSP's position on these issues is that (1) the Fifth Circuit has not considered whether it will affirm the Commission's "inherently suspect" analysis at all or as applied to this type of case in light of *California Dental*, (2) the Fifth Circuit will apply its own *Viazis* decision — a decision on which the Commission, the ALJ, and NTSP all disagree on the correct interpretation — to determine whether there is sufficient evidence of an antitrust violation in this case,[14] (3) the Fifth Circuit will address whether NTSP was denied due process when the ALJ and the Commission refused it access to data that could prove NTSP's procompetitive justifications,[15] (4) the Fifth Circuit will have the benefit of an arbitration decision, released shortly before the Commission's decision, finding that a physician group

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[12] Respondent's Appeal Brief, filed January 13, 2005; Respondent's Reply Brief, filed April 14, 2005 ("RRB").

[13] *See Howard v. FAA*, 17 F.3d 1213, 1215 (9th Cir. 1994) ("Purely legal questions are reviewed *de novo*."); *Garcia v. Sec'y of Labor*, 10 F.3d 276, 278-79 (5th Cir. 1993) (reviewing agency interpretation and application of clear legal standard *de novo*).

[14] In fact, the Commission reviewed and modified the ALJ's interpretation of *Viazis* and related finding that NTSP did not meet the concerted action requirement simply because it is an organization of otherwise competing physicians, even though neither NTSP nor Complaint Counsel appealed this ruling.

[15] Agency decisions implicating due process are reviewed *de novo*. *See Western Energy Co. v. U.S. Dep't of the Interior*, 932 F.2d 807, 809 (9th Cir. 1991) (applying *de novo* review to claims that an administrative agency violated constitutional rights).

facing allegations similar to those against NTSP did not violate antitrust laws,[16] and (5) the Fifth Circuit will consider whether the Commission's decision and order in this case conflict with the policies announced in its advisory letters to physician groups and its Statements of Antitrust Enforcement Policy in Health Care.[17] Based on the arguments explained above, NTSP has made a substantial showing on the merits of its appeal.

Further adding to the complexity and importance of this case is that it involves the health care industry — an industry currently having little success in increasing efficiency or controlling costs[18] — and an entity trying to create efficiencies and control costs through teamwork and spillover effects from managed care risk contracts. No one — not even the Commission in its opinion finding against NTSP — denies that spillover effects can exist and can be beneficial.[19] NTSP's experts, including Dr. Gail Wilensky, a White House advisor and former head of the agencies that administer Medicare and Medicaid and advise Congress on Medicare issues, found that NTSP's challenged behavior created spillover effects and that these effects and NTSP's

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[16] In the Matter of the Arbitration between United Healthcare of Illinois, Inc. and Advocate Health Care Network (American Arbitration Association Nov. 18, 2005), filed by NTSP with the Commission on November 30, 2005.

[17] *See* Bay Area Preferred Physicians Advisory Opinion, letter from Jeffrey W. Brennan to Martin J. Thompson, dated September 23, 2003 (noting that "[s]o long as payers have an effective opportunity to contract with physicians individually," an IPA's "refusal to administer contracts to which fewer than half its members subscribe is less likely to have anticompetitive effects"); PriMed Physicians Advisory Opinion, letter from Jeffrey W. Brennan to Gregory G. Binford, dated February 6, 2003 (finding that "[t]he collection and public dissemination of accurate information and expressions of opinion on matters of public interest usually do not raise concerns under the antitrust laws, even when physicians or other groups composed of competitors do so collectively"); DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, Statement 9C (allowing agents to provide objective information to providers and help providers understand contracts offered).

An agency may not ignore its own substantive policies or precedents. *See Nat'l Black Media Coalition v. FCC*, 775 F.2d 342, 348 n.7 (D.C. Cir. 1985).

[18] RX 1752 (Exh. B); RX 1753 (Exh. C); RX 1850 (Exh. D); Wilensky, Tr. 2183-85 (Exh. E); RRB at 32-33.

[19] Opinion of the Commission at 33 ("We do not question that NTSP's risk contract and its physicians who participate in it achieve efficiencies, and it could even be possible for these efficiencies to spillover to its non-risk contract in certain circumstances.").

business model in general were beneficial to the industry.[20] All of the empirical data available to NTSP and presented to the ALJ and the Commission supported the existence of spillover effects.[21] The Commission also refused NTSP access to data showing the efficacy of the spillover model, even in the face to Complaint Counsel's expert's admission that he had no data proving that NTSP's utilization-management model was less effective than the Commission's clinical integration model in improving efficiencies and quality of care.[22]

Despite this evidence, the Commission still chose to apply an "inherently suspect" analysis to NTSP's behavior and drafted an order that limits NTSP's attempts to create efficiency only to those complying with the Commission's narrow and unproven definitions of financial and clinical integration.[23] While the Commission claimed to have extensive experience in the health care industry to guide its decision in this case,[24] it relies on no data and its citations to previous experience involve only consent orders entered against physician groups with behavior and business models markedly different from that of NTSP.[25] The Commission noted that this was the first time in over 20 years that it had "the benefit of a full administrative trial and record" for a physician network case.[26]

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[20] Wilensky, Tr. 2161-72, 2176-81, 2191-92, 2204-05 (Exh. F); RX 3118 at ¶¶ 83-100 (Exh. G, *in camera*); RX 3130 (Exh. H, *in camera*), Maness, Tr. 1990-91, 2075-78 (Exh. I).

[21] RX 3130 (Exh. H, *in camera*); RX 3118 at ¶ 95 (Exh. G, *in camera*); Maness, Tr. 2075-76 (Exh. I).

[22] *E.g.,* Casalino, Tr. 2894 (Exh. J).

[23] Final Order at Section I.I and I.J, defining "qualified clinically-integrated joint arrangement" and "qualified risk-sharing joint arrangement."

[24] When discussing its experience, the Commission cites to consent orders and references "past relief in settlement in similar cases." Opinion of the Commission at 1, 37.

[25] *E.g., In the Matter of Piedmont Health Alliance, Inc.*, Docket No. 9314 (consent order issued Oct. 1, 2004). Piedmont Health Alliance had bound most of the physicians in a four-county area to deal exclusively through PHA and accept only PHA-negotiated prices. *In the Matter of Piedmont Health Alliance, Inc.*, Docket No. 9314, Complaint at ¶¶ 1, 19-20, 25.

[26] Opinion of the Commission at 2. And the record here was not even truly complete because of the physician performance data denied to NTSP. Orders on Motions of Non-Party Payors to Quash or Limit

NTSP also can make a substantial showing on the merits as to the appeal of the order itself. The order entered by the Commission was broader than that of the fact-finder, the ALJ. The Commission based this broad order on the form of prior consent orders. But as the ALJ noted, "'[T]he circumstances surrounding ... negotiated [consent decrees] are so different that they cannot be persuasively cited in a litigation context.'"[27] To the extent a cease-and-desist order is found appropriate at all in light of the legal issues raised by NTSP on appeal, the ALJ correctly found in entering his order that the order proposed by Complaint Counsel (and now adopted by the Commission) was overly broad.[28] The Fifth Circuit has the authority to modify a Commission order, including one with an overbroad remedy.[29]

As discussed in the next section, there will be substantial irreparable injury to NTSP and non-party physicians, patients, and health plans without a stay, and the balance of equities weighs heavily in favor of NTSP. Therefore, under both the Commission and Fifth Circuit standards, the foregoing showing on the merits of the appeal is more than enough to support the granting of a stay.

B. Balance of Equities

As applied to every significant provision in the order, the balance of equities — whether there is irreparable harm to NTSP if a stay is not granted, whether others will be harmed if a stay is granted, and whether a stay is in the public interest — weighs heavily in favor of NTSP.

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the Subpoenas Duces Tecum served by NTSP, entered on 1/30/04 and 2/4/04, quashing NTSP's discovery requests for the payors' flat file data.

[27] Initial Decision ("ID") at 89 (quoting *United States v. E.I. du Pont de Nemours*, 366 U.S. 316, 330 n.12 (1961).

[28] ID at 88-90.

[29] 15 U.S.C. § 45(d); *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 613 (1946).

The first factor, irreparable harm, examines the consequences of imposing the order on NTSP, assuming that NTSP ultimately succeeds on the merits of its appeal.[30] It is irrelevant to this inquiry whether the Commission considers this harm to be proper remedial consequences.[31] Irreparable harm was found when compliance with an order that is then reversed on appeal would result in unrecoverable costs and business losses,[32] confusion and costly notification,[33] harm to reputation that cannot be easily ameliorated,[34] prohibition of potentially lawful activities,[35] or a loss of First Amendment rights.[36] NTSP will suffer each of these consequences if a stay is not granted.

The Commission considers the second and third factors, harm to others and the public interest, together.[37] In this case, not only will a stay not harm others or the public interest, but not granting the stay would cause harm to third-parties and the public interest because the order adversely affects non-party physicians, patients, and health plans through mandatory termination of payor contracts and prohibition of NTSP's spillover business model. The mandatory termination is ordered even though NTSP's contracts were found to be at or below the rates offered by payors to other entities and even though Complaint Counsel offered no data to rebut the evidence showing that NTSP's total costs (rate x utilization) were lower than for other

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[30] *Novartis Corp.*, 128 F.T.C. at 235-36.

[31] *Id.* (recognizing that if the appeals court overturned the FTC, any lost sales or harm to reputation may be difficult to ameliorate, even though the FTC considered those to be proper remedial consequences).

[32] *Id.*; *Cal. Dental Ass'n*, 1996 FTC LEXIS 277 at *6; *Fla. Businessmen for Free Enterprise v. City of Hollywood*, 648 F.2d 956, 958 (5th Cir. 1981).

[33] *Cal. Dental Ass'n*, 1996 FTC LEXIS 277 at *6-7.

[34] *Novartis Corp.*, 128 F.T.C. at 235-36.

[35] *Toys "R" Us*, 126 F.T.C. at 698-99.

[36] *Fla. Businessmen for Free Enterprise*, 648 F.2d at 958; *Novartis Corp.*, 128 F.T.C. at 238 (concurring opinion of Swindle).

[37] *Toys "R" Us*, 126 F.T.C. at 700.

groups. Therefore, the balance of equities supports the granting of a stay, regardless of NTSP's showing of likelihood of success on the merits.[38]

1. Section II of the Order

Section II of the order is a mandatory injunction preventing NTSP from negotiating on any subject with payors on behalf of physicians, refusing to deal with payors, discussing any terms physicians are willing to accept (not limited to price or other economic terms) from payors, and communicating information from and among physicians (not limited to price or other economic information). The only exemptions from the prohibitions in Section II are qualified risk-sharing or clinically-integrated joint arrangements, as narrowly defined by the Commission.

The Commission greatly increased the scope of Section II's prohibitions from those included in the ALJ's order. The ALJ properly found that NTSP should not be prohibited from refusing to deal with payors or from communicating purely factual information regarding payors, objective comparisons between payor offers, or views relevant to health plans.[39] All of Section II, both the provisions agreed with by the ALJ and the expansions crafted by the Commission, should be stayed because this mandatory injunction will cause NTSP to incur unrecoverable costs; create confusion among physicians, patients, and health plans; adversely affect NTSP's reputation and viability; prevent NTSP from participating in lawful and potentially lawful conduct, including exercise of its right to contract; and infringe on NTSP's First Amendment rights. These effects constitute not only irreparable harm, but also harm to third-party physicians, patients, and health plans as well as harm to the public interest because of issues

[38] *Cal. Dental Ass'n*, 1996 FTC LEXIS 277 at *12 ("In the light of the other three factors, our skepticism regarding respondent's likelihood of success in this case does not preclude us from staying [parts of the order]."

[39] ID at 94.

regarding patient care and the efficiency and quality of care created by NTSP's spillover business model. Therefore, Section II of the order should be stayed.

First, this section's limitations on NTSP's conduct raises significant issues regarding cost to NTSP, confusion to third-party physicians, patients, and health plans regarding NTSP's functions and policies, and NTSP's ability to continue to participate in lawful activities. To comply with the order, NTSP will have to change current policies regarding entering into, messengering, and terminating contracts, as well as to seek new Physician Participation Agreements with each of its hundreds of physicians.[40] If the order were then reversed on appeal, NTSP would have to change again its contracting policies, seek to reinstate hundreds of rescinded Physician Participation Agreements, and, to the extent it could, undo the effects of the actions taken under the order.[41] This would be costly and confusing to physicians and payors. The Commission found a similar situation warranted a stay when the order required a "repeated change of policy and notification of members [that would be] both costly and may create significant confusion about the law."[42]

The broad restrictions NTSP must now craft into its policies and physician agreements also potentially prevent NTSP from making lawful unilateral decisions and disseminating information to physicians and patients regarding health care in general as well as particular payors and contracts. Although the Commission rejected NTSP's argument that it never acts as a collective of physicians and found that NTSP's communications could be anticompetitive, the effect of the order is that NTSP cannot safely act unilaterally as an entity in dealing with payors

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[40] Declaration of Karen Van Wagner, Ph.D ("Van Wagner Declaration") at ¶ 6 (Exh. K).

[41] *Id.*

[42] *Cal. Dental Ass'n*, 1996 FTC LEXIS 277 at *7.

or contracts related to physician services.[43] It is also undisputed that NTSP's communications may have procompetitive effects.[44] In situations such as these, where potentially overly broad mandates are required to enforce an order, the Commission has found that "for the relatively brief period of a stay pending appeal, [movant's] asserted difficulties in distinguishing between lawful [unilateral] conduct and unlawful conduct support granting a stay."[45] Further, NTSP's inability to terminate payor contracts, regardless of payor breaches of contract (such as those by Cigna and Medical Select Management[46]) or illegal conduct (such as that found by the State of Texas as to Aetna, Cigna, United and Medical Select Management[47]), exposes NTSP to potential liability and deprives it of a contract right.[48] As the Fifth Circuit has held, "The right [of the movant] to contract must be accommodated by the Commission if at all possible with its statutory duty to formulate a remedy...."[49]

Second, under this section, NTSP is basically relegated to an all-or-nothing messenger of payor contracts.[50] The practical effect of this requirement is to block NTSP's spillover business

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[43] *Viazis v. Am. Ass'n of Orthodontists*, 314 F.2d 758, 764 (5th Cir. 2002) ("Despite the fact that '[a] trade association by its nature involves collective action by competitors[,] . . . [it] is not by its nature a "walking conspiracy", its every denial of some benefit amounting to an unreasonable restraint of trade." (quoting *Consol. Metal Prods., Inc. v. Am. Petroleum Inst.*, 846 F.2d 284, 293-94 (5th Cir. 1988)).

[44] DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, Statement 9C (allowing agents to provide objective information to providers and help providers understand contracts offered); PriMed Physicians Advisory Opinion, letter from Jeffrey W. Brennan to Gregory G. Binford, dated February 6, 2003 ("Increasing the amount of information available to patients, employers, physicians, and other interested parties can improve the functioning of markets and foster, rather than hinder, competition and consumer welfare. In most instances, physicians' collection and publication of such information, and their advocacy of a point of view on issues affecting the organization, delivery, and financing of health care services, would not likely impair competition or violate the antitrust laws.").

[45] *Toys "R" Us*, 126 F.T.C. at 697-98.

[46] *E.g.,* Initial Decision Findings of Fact ("IDF") 218-19, 228; RX 335 (Exh. L); Van Wagner, Tr. 1652-53, 1769, 1979-80 (Exh. M); Grizzle, Tr. 940-42 (Exh. N, *in camera*).

[47] *E.g.*, IDF 194, 257-58, 357-60, 362.

[48] Van Wagner Declaration at ¶ 5 (Exh. K).

[49] *Arthur Murray Studio of Wash., Inc. v. F.T.C.*, 458 F.2d 622. 625 (5th Cir. 1972).

[50] Final Order, Section II.

model, therefore presenting a significant danger to NTSP's reputation and continued viability.[51] The Commission has found irreparable injury when an order results in "lost sales or reputational harm... [that] may indeed be difficult to ameliorate."[52]

Disruption of the spillover model pending judicial review also harms the public interest by preventing NTSP's efforts to increase efficiency and quality of care in the health care industry.[53] The ALJ and the Commission acknowledge that there can be procompetitive effects of NTSP's spillover business model.[54] Yet the Commission tries to limit the efficiency-creating conduct in which an entity may take part to only financial-risk and clinical integration, as defined by the Commission.[55] In a case where no anticompetitive effects were shown[56] and what little empirical evidence there is supports NTSP's efficiency and quality-of-care claims,[57] the public interest (and the law) is against placing strict limits on attempts to improve the health care industry. Further, physician relationships and patient care may be affected by the harm to NTSP's business model and viability.[58] The Fifth Circuit has found that a stay serves the public interest when patient interests could be seriously compromised by enforcement of an order.[59]

Finally, the order severely limits NTSP's communications with its hundreds of participating physicians as well as with every payor in the Dallas-Fort Worth Metroplex, and

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[51] Van Wagner Declaration at ¶ 5 (Exh. K).

[52] *Novartis Corp.*, 128 F.T.C. at 236.

[53] Van Wagner Declaration at ¶ 5 (Exh. K); Declaration of Paul Grant, M.D. ("Grant Declaration") at ¶ 5 (Exh. O). See also *supra* note 20.

[54] *See* Opinion of the Commission at 33 ("We do not question that NTSP's risk contract and its physicians who participate in it achieve efficiencies, and it could even be possible for these efficiencies to spillover to its non-risk contract in certain circumstances."); Complaint Counsel's Answering Brief at 40 (spillover is "certainly plausible in theory").

[55] Final Order at Sections I.I, I.J, and II.

[56] ID at 82; IDF 188, 217, 328-29.

[57] RX 3130 (Exh. H, *in camera*); RX 3118 at ¶ 95 (Exh. G, *in camera*).

[58] Grant Declaration at ¶ 5 (Exh. O).

[59] *United States v. Baylor Univ. Med. Ctr.*, 711 F.2d 38, 40 (5th Cir. 1983).

therefore infringes NTSP's First Amendment rights.[60] As shown by the Commission's omission of the ALJ's caveats on the limitation of NTSP's speech, this section now prevents NTSP from commenting on payors' actions and contracts and from communicating with its participating physicians concerning even factual data or objective comparisons. This is despite the fact that Complaint Counsel admitted NTSP's speaking out may not be in restraint of trade[61] and the Commission has acknowledged the procompetitive effects of information sharing in the health care industry.[62] The Fifth Circuit has held that "[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury."[63] Especially here, where there has been no showing of anticompetitive effects from NTSP's communications and those communications can have procompetitive effects,[64] it would be improper for the Commission to infringe upon NTSP's First Amendment rights pending judicial review of the order.

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[60] Van Wagner Declaration at ¶¶ 3, 6 (Exh. K).

[61] Complaint Counsel's Answering Brief at 20 ("[A]bsent other evidence, mere collective expression of opinion by competitors, without any agreement on their behavior in the marketplace, does not establish an agreement in restraint of trade.").

[62] DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, Statement 9C (allowing agents to provide objective information to providers and help providers understand contracts offered); PriMed Physicians Advisory Opinion, letter from Jeffrey W. Brennan to Gregory G. Binford, dated February 6, 2003 ("Increasing the amount of information available to patients, employers, physicians, and other interested parties can improve the functioning of markets and foster, rather than hinder, competition and consumer welfare. In most instances, physicians' collection and publication of such information, and their advocacy of a point of view on issues affecting the organization, delivery, and financing of health care services, would not likely impair competition or violate the antitrust laws.").

[63] *Fla. Businessmen for Free Enterprise*, 648 F.2d at 958.

[64] DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, Statement 9C (allowing agents to provide objective information to providers and help providers understand contracts offered); PriMed Physicians Advisory Opinion, letter from Jeffrey W. Brennan to Gregory G. Binford, dated February 6, 2003 ("Increasing the amount of information available to patients, employers, physicians, and other interested parties can improve the functioning of markets and foster, rather than hinder, competition and consumer welfare. In most instances, physicians' collection and publication of such information, and their advocacy of a point of view on issues affecting the organization, delivery, and financing of health care services, would not likely impair competition or violate the antitrust laws.").

Even one of these results alone swings the balance of equities in NTSP's favor. Because NTSP has shown multiple inequitable results from enforcement of Section II of the order at this time, a stay is proper. Further, because the Commission had no evidence of a physician conspiracy in this case,[65] Section II does not address overt acts in restraint of trade but instead contains "fencing in" provisions. As the Commission has noted, fencing-in provisions are more easily stayed because they are "less likely to cause immediate harm to the public."[66]

2. Section IV of the Order

Section IV of the order has two main requirements. The first is that NTSP notify physicians and payors regarding the order and Complaint.[67] The second is that NTSP must terminate all contracts with payors (except for its risk contracts) within one year after the effective date of the order.[68] This termination of NTSP's contracts with payors will also terminate the contracts as to non-party participating physicians and patients.[69] Section IV should be stayed because it will cause NTSP, payors and physicians to incur unrecoverable costs, create confusion among physicians, patients, and health plans, and adversely affect NTSP's reputation and business viability. These effects constitute not only irreparable harm, but also harm to third-party physicians, patients, and health plans as well as harm to the public interest because of the disruption of patient care and the financial impact on non-party physicians. Therefore, Section IV of the order should be stayed.

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[65] IDF 71-77; RAB at 16-17.

[66] *Toys "R" Us*, 126 F.T.C. at 700.

[67] Final Order at Sections IV.A and IV.D.

[68] Final Order at Section IV.B.

[69] Van Wagner Declaration at ¶ 4 (Exh. K).

First, the notification requirements require NTSP to notify each of its hundreds of participating physicians as well as every payor in the Dallas-Fort Worth Metroplex.[70] That notice would cause NTSP to suffer unrecoverable costs and business losses, confuse physicians, patients, and payors, and cause harm to NTSP's reputation. As noted previously, the Commission has found reputational harm and business losses to be irreparable injury because they are difficult to recover.[71] Further, if the order were then reversed on appeal, NTSP would have to again notify all physicians and payors, resulting in further costs and a great deal of confusion.[72]

Second, the mandated termination of payor contracts that will result if the order is enforced will cause harm to NTSP and, importantly, to non-party physicians, patients, health plans, and the public interest. Termination of the NTSP contracts will disrupt the spillover effects NTSP has achieved, which made it the "top performer in the Metroplex."[73] Not only is it against the public interest to interfere with these spillover effects, but it will cause serious harm to NTSP's reputation and viability in the marketplace to have these contracts terminate and spillover effects to be interrupted.[74]

Further, termination of contracts will have immediate and serious adverse effects on non-parties to this proceeding. This section of the order has the potential to disrupt not only the medical practices of the non-party physicians, but the operation of health plans and patient care for the over 200,000 lives covered by the 13 contracts that NTSP (and, therefore, the non-party

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[70] Van Wagner Declaration at ¶¶ 3, 6 (Exh. K).
[71] *Novartis Corp.*, 128 F.T.C. at 235-36.
[72] Van Wagner Declaration at ¶ 6 (Exh. K).
[73] Lovelady, Tr. 2665, 2668 (Exh. P).
[74] Van Wagner Declaration at ¶ 5 (Exh. K); Grant Declaration at ¶ 5 (Exh. O).

participating physicians) is required to terminate.[75] Termination also would result in financial harm to the non-party physicians[76] and payors. The Fifth Circuit stayed an order to serve the public interest in a similar situation where there were issues of disruption of medical services to patients and significant interruption of a hospital's normal procedures.[77] It is important to note also that the continuation of these contracts is not harmful — the only contracts complained of have been terminated, replaced, or are already terminable-at-will by the payors.[78] And the ALJ found that the rates offered by payors to NTSP were no higher than rates offered in the market to other physicians and physician groups.[79]

Even one of these results alone swings the balance of equities in NTSP's favor. Because NTSP has shown a number of inequitable results of enforcing Section IV of the order at this time, a stay of Section IV is proper. Further, because the Commission had no evidence of a direct conspiracy in this case,[80] Section IV does not address overt acts in restraint of trade but instead contains "fencing in" provisions. As the Commission has noted, fencing-in provisions are more easily stayed because they are "less likely to cause immediate harm to the public."[81]

3. Section VI of the Order

Section VI of the order requires NTSP to permit the Commission to inspect its records and interview employees. Section VI should be stayed during NTSP's appeal because the section is fatally flawed and disregards federal and state law. There is no provision in the order

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[75] Grant Declaration at ¶¶ 3-4 (Exh. O).

[76] Grant Declaration at ¶¶ 3-4 (Exh. O).

[77] *Baylor Univ. Med. Ctr.*, 711 F.2d at 40.

[78] Van Wagner Declaration at ¶ 7 (Exh. K); Roberts, Tr. 549 (no current contract between NTSP and Aetna) (Exh. Q); CX 809 at ¶ 1 (Exh. R, *in camera*) (Cigna contract terminable-at-will since September 2004).

[79] ID at 83.

[80] See *supra* note 65.

[81] *Id.*

exempting attorney-client, physician-patient and other privileged and confidential documents and information from this order, and the order therefore infringes on the rights of patients, physicians, and NTSP.[82] Further, allowing the Commission access to these materials only if and when the order is affirmed by the Fifth Circuit will not harm other persons or the public interest. Therefore, Section VI of the order should be stayed.

4. The Ancillary Provisions of the Order

The remainder of the order's provisions, not discussed above, are not substantive restrictions on NTSP, but merely ancillary to the provisions specifically addressed in this motion.[83] Because NTSP has shown that each of the substantive provisions should be stayed, it is appropriate for the Commission to stay the entire order, including these ancillary provisions, which have no purpose or meaning if the remainder of the order is stayed.

PRAYER FOR RELIEF

Because North Texas Specialty Physicians has shown that it meets the Federal Trade Commission's requirements for the granting of a stay, North Texas Specialty Physicians requests that the Commission stay the Final Order, effective upon NTSP's filing of a petition for review and remaining in effect until 90 days after the U.S. Court of Appeals for the Fifth Circuit issues a decision vacating the Final Order or otherwise ruling on the petition for review.

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[82] *Doe v. Se. Pa. Transp. Auth.*, 72 F.3d 1133, 1137 (3d Cir. 1995) (recognizing that unauthorized disclosure of a patient's medical records violates the patient's Constitutional right to privacy); *Guzzino v. Felterman,* 174 F.R.D. 59, 60-61 (W.D. La. 1997) (recognizing the attorney-client privilege as the oldest of the privileges for confidential communications); *see also* Health Insurance Portability and Accountability Act, 45 C.F.R. 160.101, *et seq.* (placing limits on disclosure of a patient's medical information).

[83] Final Order at Section I (definitions); Final Order at Section III (notify Commission of messengering/agent arrangements); Final Order at Sections IV.C and IV.E (report to Commission on notifications sent and compliance activities); Final Order at Sections IV.F and V (notify Commission of changes in address or organization); Final Order at VII (term of order).

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 20, 2005, I caused a copy of the foregoing document to be served upon the following persons:

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1973425.1

Exhibits G, H, N, and R of North Texas Specialty Physicians' Motion for Stay of Final Order Pending Judicial Review are subject to In Camera orders.

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INDEX TO APPENDIX [PUBLIC]

A

competitively cognizable efficiency, wholly unrelated.

A word, Your Honor, about relief. Respondent has claimed that Complaint counsel have insisted that the failure to messenger a contract with nothing more would violate the antitrust laws. We have made and make no such claim. We in the Commission's Complaint do claim that the failure to submit contracts to IPA members in connection with the fixing of fee-for-service physician prices violates the antitrust laws.

The violation being established, it will be appropriate to fence in Respondent NTSP's conduct to mitigate the risk of further unlawful behavior and practical problems of order enforcement. We will seek entry of an order broadly requiring NTSP to messenger contracts, not because every failure to do so is an independent law violation but, rather, because failure to do so would permit Respondent NTSP innumerable opportunities to continue its price fixing using pretext after pretext after pretext.

Respondent NTSP, without meaning to do so, underscores this risk in its pretrial brief when it lists the myriad reasons why it, it

B

Health Expenditure Trends in OECD Countries, 1990-2001

Manfred Huber, Ph.D. and Eva Orosz, Ph.D.

This article presents data on health care spending for 30 OECD countries from OECD Health Data 2003, the latest edition of OECD's annual data collection on health systems across industrialized countries. OECD data show health care expenditures as a proportion of gross domestic product at an all-time high, due to both increased expenditures and overall economic slowdown. The article discusses similarities and differences across countries in how health care expenditures are funded and how the health care dollar is spent among types of services.

INTRODUCTION

OECD countries are currently spending record amounts on health care. In 2001, they spent an average 8.4 percent of their GDP on health care, up by 0.3 percentage points from 2000. Pressures for further growth arise from rapid advances in medical technologies, population aging, and rising public expectations. OECD data show that health care spending has outpaced economic growth over the past decade, even before the economic downturn of 2001. The latest increase in expenditure ratios, therefore, comes as no surprise. In fact, it was anticipated by several authors for individual countries, e.g., the U.S. (Heffler et al., 2003) and for Canada (Canadian Institute for Health Information, 2003).

The authors are with the Organisation for Economic Co-operation and Development (OECD). The research in this article was supported by the Centers for Medicare & Medicaid Services (CMS) under HCFA Contract Number 500-00-0010. The views expressed in this article are those of the authors and do not necessarily reflect the views of the OECD Secretariat or CMS.

Over the 1990s the gap between health spending growth and economic growth rates was roughly 1 percent for OECD countries on average, on a per-capita basis. In 2001, the latest year available for international comparisons, health care spending growth has accelerated in several OECD countries, including the U.S. (Levit et al., 2003) where it was above the unweighted OECD average.

The pressure on public budgets from accelerated health care spending has been a major policy concern in OECD countries during the past two decades (Docteur and Oxley, 2003; Imai, 2002; Mossialos and Le Grand, 1999; Ranade, 1998; Saltman and Figueras, 1997). Recent economic slowdown and a new upsurge in health care spending, especially in the U.S. has prompted a new round of discussions about desirable health policies to influence aggregate health care spending (Altman et al., 2003; Cutler, 2002).

A common approach of public health care policy in OECD countries has been to combine cost-containment strategies with long-term structural change to improve value-for-money in health care (Docteur and Oxley, 2003; Organisation for Economic Co-operation and Development, 1995). In Sweden, for example, one of the major tools for cost containment was downscaling in the hospital sector and decreasing in the number of health care personnel. Sweden is also among the few OECD countries where the number of physicians per 1,000 population did not increase during

NOTE: This is an update of previous articles on spending trends (Huber 1999; Schieber, Poullier and Greenwald, 1992). It focuses on expenditure trends since 1990 and on comparisons with recent experience in the U.S.

the 1990s.[1] But it is cost-containment measures that are often the more visible part of reforms, and those which, in many cases, directly affect households who pay for higher cost sharing, or for goods and services that are no longer reimbursed under public programs (Ros, Groenewegen, and Delnoij, 2000). Among the most recent examples is the current reform proposal in Germany (*Financial Times*, 2003). A central part of the German reform proposal, recently enacted and due to be implemented at the beginning of next year, is a shift of health care expenditures to private financing; for example, consumers will face higher cost sharing for prescription drugs and dental care.

In several countries, an important feature of the changes of health care financing in recent years has been a reduction in the autonomy granted to social insurance regimes to simply pass through higher costs into higher compulsory contributions. This has been the case in the Czech Republic, France, Germany, and Hungary. Because of the depressive effect on employment that could result from higher employer paid social charges, the control of contribution rates has become an explicit policy target. In order to reconcile this with the financial viability of insurance regimes, three related strategies have been followed by governments: (1) impose budget constraints on providers, (2) require individuals to bear a greater share of expenditures, through increasing copayments, and (3) ensure that access to care remains available to the poor (general taxation has financed a growing proportion of care, particularly by financing copayments for those on low incomes). France has introduced municipal social insurance specifically to address this last point (Imai, Jacobzone, and Lenain, 2000).

[1] This ratio stayed the same in 2000 as the OECD average, while in 1990 it was 20 percent higher.

Current problems in many countries, however, show that strong control on public spending on health care might lead to difficulties in terms of other policy goals (Docteur and Oxley, 2003). Canada, Denmark, United Kingdom, and the U.S. are currently experiencing shortages of nurses and even physicians.

In Canada, the declining Federal health transfers put a strain on provincial health care systems (Matteo, 2000). During 4 years in the mid-1990s, real total health care spending in Canada fell. This coincided with a decline in the satisfaction with the health care system. For instance, the proportion of people saying that the health care system needed only minor changes dropped from 56 percent in 1988 to 20 percent in 1998. Concerns about underfunding, system administration, and access to specialty care were among the main public concerns (Donelan et al., 1999). Following this period of restraint, public spending increased by an annual rate of 5.1 percent between 1997 and 2001. Since 1998 public sector spending grew faster than that from private sources, and its share was about 73 percent of the total in 2001.

The growth rate of total health care expenditures abated in the U.S. too, during the period of 1992-1999. While average growth rate of total health care expenditures was 5.5 percent in the 1980s (2.5 times higher than GDP growth), it was only 2.5 percent between 1992 and 1999.[2] This slow-down is generally seen as due to managed care replacing indemnity insurance as the primary form of private health insurance. Managed care, coupled with robust economic growth, led to an unprecedented stability in the health expenditure share of GDP over this 7-year period (Cowan,

[2] Calculated at constant, 1995 GDP price level.

et al., 2001). While governments in other countries managed to lower prices for providers unilaterally, a major tool of managed-care insurers was to exclude providers from their network. "As a result, lower prices came along with constrained access to providers in the United States, where it did not in other countries." (Cutler, 2002).

Consumers in OECD countries are experiencing considerable waiting times for elective surgery (Hurst and Siciliani, 2003) and increasing cost sharing. In a recent survey, shortages of medical personnel, waiting times, and inadequate government funding led the list of concerns in Australia, Canada, New Zealand, and the United Kingdom; high costs and inadequate coverage topped the list for the U.S. (Blendon et al., 2003). Furthermore, a wave of recent medical and technological advances and rising patients' expectations can be expected to put increased pressure on public expenditure on health in the near future.

TRENDS IN EXPENDITURE GROWTH RELATIVE TO GDP

For OECD countries on average, the share of GDP devoted to health care increased markedly in 2001 after a period of relatively stable health care expenditures ratios (Table 1 and Figure 1). This is partially due to slow economic growth. In 2001, OECD countries spent an additional 1.1 percent of GDP on health care compared to 1990, bringing the average up to 8.4 percent.[3]

The U.S. devoted the highest share of GDP to health throughout the decade, increasing to 13.7 percent in 2001. Internationally harmonized expenditure ratios for the U.S. differ slightly from those published by CMS. The OECD Secretariat reports internationally harmonized U.S. GDP that is 0.6 percent lower than that published by the U.S. Department of Commerce, Bureau of Economic Analysis. Moreover, the OECD definition for total health care expenditures excludes some small spending items, such as research and development, resulting in total health care spending which, for 2001, is 2.3 percent lower than that reported nationally. Detailed documentation of national data sources and estimation methods used in health accounts is available as part of the OECD information system (Organisation for Economic Co-operation and Development, 2003a). Following the U.S. in 2001 was Switzerland spending 10.9 percent, and Germany spending 10.7 percent of GDP on health care. At the other end of the scale, the Slovak Republic and Korea spent less than 6 percent of GDP on health care (Figure 2).[4]

Studying the growth patterns of health expenditure and GDP separately provides further insight into international variations in the trend in health care expenditures ratios. In Table 2, both components have been expressed in per capita and in real terms, using the same GDP deflator.[5] The margin by which health care expenditures growth outpaced GDP growth can be read from Figure 3 by the relative distance from the diagonal line. This diagonal delimits the sample of countries with faster growth of per-capita health care spending than GDP growth.

[3] Data availability influences the number of countries than can be included in calculating OECD averages for different time periods. Comparable data for the last three decades were available only in 18 OECD countries, and in 28 countries for the period of 1990 to 2000. Data of 2001 have been reported to the OECD for 24 OECD countries until August 2003.

[4] Luxembourg also has a low ratio of health spending to GDP, but data comparability for this small country is limited. This is mainly due to the close integration of its health care system and economy with neighboring countries, which makes cross-border adjustments extremely difficult.

[5] Real growth was calculated using the GDP deflator throughout this article, instead of using health-care specific deflators. The reason for this choice is that countries differ in the construction of national health price indexes to a degree which would distort comparisons of real growth across countries.

Table 1

Total Health Care Expenditures as a Percent of Gross Domestic Product, by Country: 1970-2001

Country	1970	1980	1990	1993	1998	2000	2001
				Percent			
Australia	5.6 (1971)	7.0	7.8	8.2	8.6	8.9	—
Austria	5.3	7.6	7.1	7.9	7.7	7.7	7.7
Belgium	4.0	6.4	7.4	8.1	8.4	8.6	9.0
Canada	7.0	7.1	9.0	9.9	9.1	9.2	9.7
Czech Republic	—	—	5.0	7.2	7.1	7.1	7.3
Denmark	8.0 (1971)	9.1	8.5	8.8	8.4	8.3	8.6
Finland	5.6	6.4	7.8	8.3	6.9	6.7	7.0
France	—	—	8.6	9.4	9.3	9.3	9.5
Germany[1]	6.2	8.7	9.9 (1992)	9.9	10.6	10.6	10.7
Greece	6.1	6.6	7.4	8.8	9.4	9.4	9.4
Hungary	—	—	7.1 (1991)	7.7	6.9	6.7	6.8
Iceland	4.7	6.2	8.0	8.5	8.6	9.3	9.2
Ireland	5.1	8.4	6.1	7.0	6.2	6.4	6.5
Italy	—	—	8.0	8.1	7.7	8.2	8.4
Japan	4.5	6.4	5.9	6.4	7.1	7.6	—
Korea	—	—	4.8	4.7	5.1	5.9	—
Luxembourg	3.6	5.9	6.1	6.2	5.8	5.6	—
Mexico	—	—	4.5	6.1	5.2	5.6	6.6
Netherlands	6.9 (1972)	7.5	8.0	8.5	8.6	8.6	8.9
New Zealand	5.1	5.9	6.9	7.2	8.0	8.0	8.2
Norway	4.4	6.9	7.7	8.0	8.5	7.7	8.3
Poland	—	—	5.3	6.4	6.4	6.0	6.3
Portugal	2.6	5.6	6.2	7.3	8.6	9.0	9.2
Slovak Republic	—	—	—	—	5.8	5.7	5.7
Spain	3.6	5.4	6.7	7.5	7.5	7.5	7.5
Sweden	6.7	8.8	8.2	8.6	8.3	8.4	8.7
Switzerland	5.6	7.6	8.5	9.6	10.6	10.7	10.9
Turkey	2.4	3.3	3.6	3.7	4.8	4.8 (1998)	—
United Kingdom	4.5	5.6	6.0	6.9	6.9	7.3	7.6
United States	6.9	8.7	11.9	13.3	13.0	13.1	13.9
OECD Average Countries (28)[2]	NA	NA	7.3	8.0	8.0	8.1	8.4
OECD Average Countries (18)[3]	5.3	7.0	7.6	8.3	8.3	8.4	8.6
European Union Average Countries (14)[4]	NA	NA	7.6	8.2	8.2	8.3	8.5

[1] For all years preceding 1990, data for Germany refer to West Germany.

[2] The average excludes the Slovak Republic and Turkey. The 2001 average includes 2000 figures for Australia, Japan, Korea, and Luxembourg.

[3] The average excludes Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland, and Turkey.

[4] The average includes Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

NOTES: OECD is Organisation for Economic Co-operation and Development. NA is not available. Numbers in parentheses are the number of countries for which data are available. Not all countries report data for the years shown in column headers. Where this is the case, closest available year, shown in parentheses, has been used.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

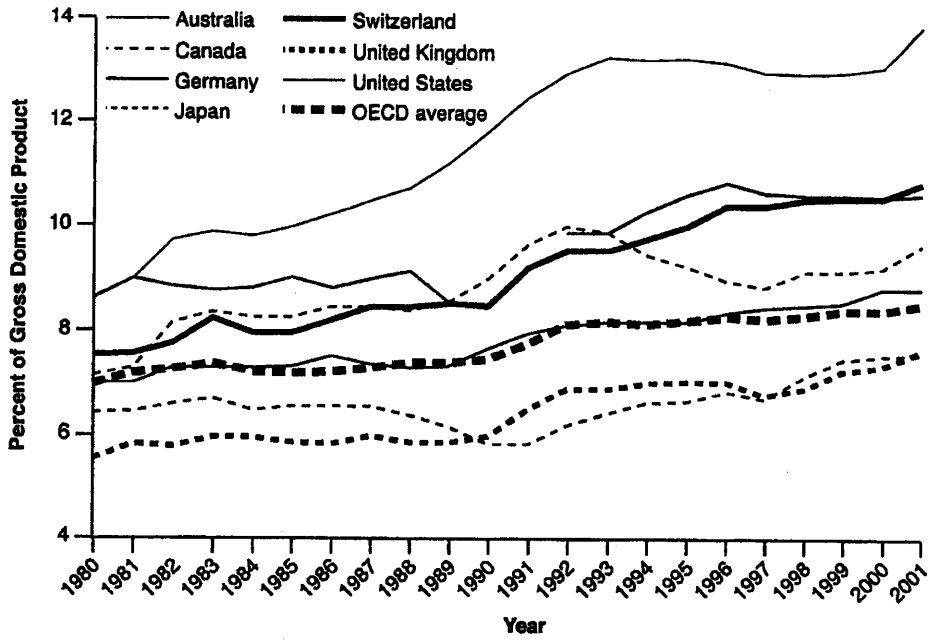
For an (unweighted) average of 24 countries, there was a gap of 1 percentage point between the average annual growth of per-capita GDP and per-capita health care spending (3.1 versus 2.0 percent). In other words, the annual increase in per capita spending on health care across OECD countries has outpaced overall economic growth per capita by around 50 percent over the past decade.

For health care expenditures trends in OECD countries, the last decade can be roughly divided into three different periods in terms of health care expenditures growth rate and health care expenditures ratio to GDP (Table 3).[6] The first 3 years of the decade (1990 to 1992) saw considerably

[6] A decade is a rather arbitrary construct and might hide the most important features of health expenditure trends. Hence, Tables 1 and 3 also present the characteristic subperiods (or their border years) within the 1990s.

Figure 1

Total Health Care Expenditures as a Percent of Gross Domestic Product: 1980-2001



NOTES: OECD is Organisation for Economic Co-operation and Development. OECD average excludes Czech Republic, France, Hungary, Italy, Mexico, Poland, Slovak Republic, and Turkey due to incomplete data availability. For Germany, the series break between 1990 and 1992 (first year after reunification).

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

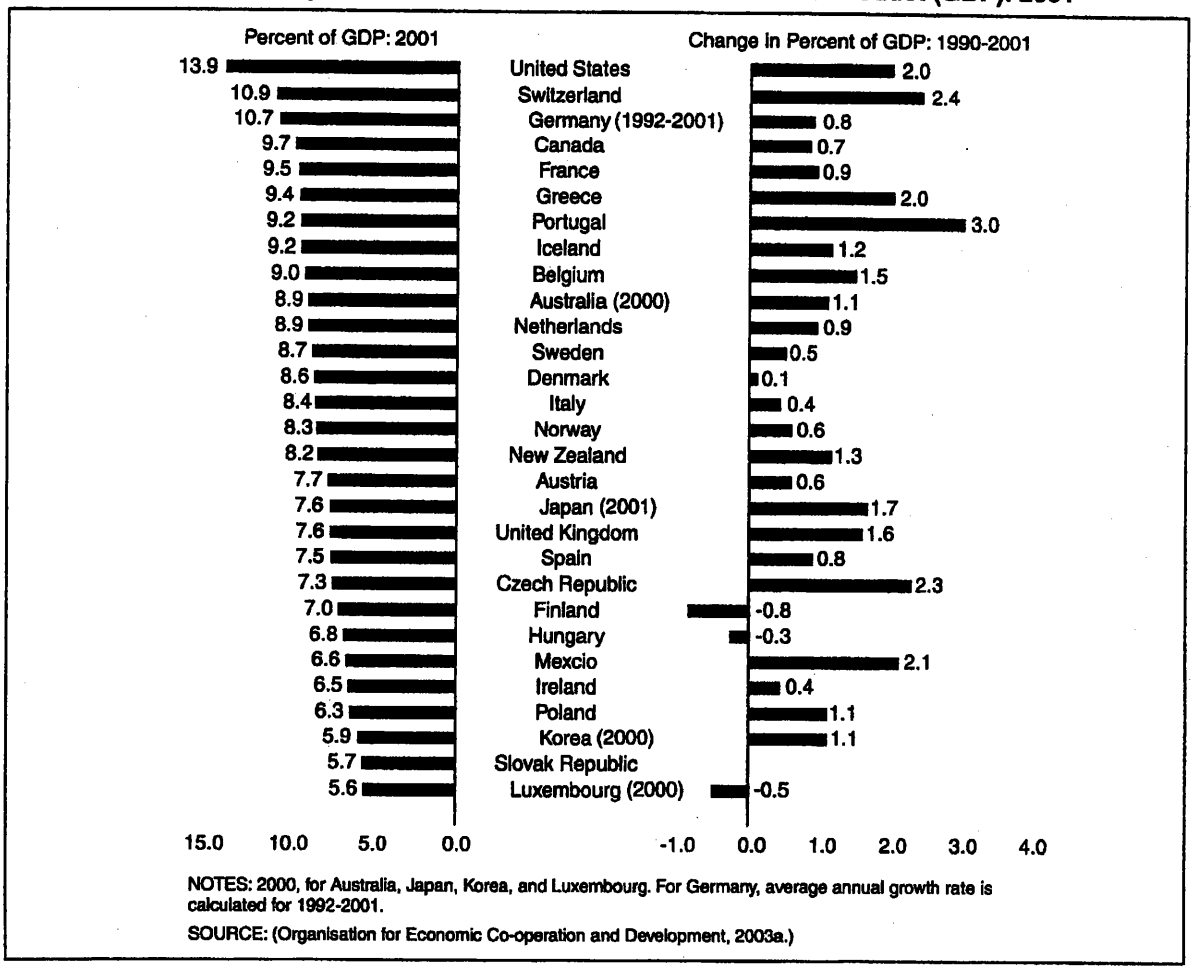
higher growth than the 5-year period from 1993 to 1997, when governments in many countries applied cost-containment measures (Anell and Svarvar, 1999; Häkkinen, 1999; Mossialos and Le Grand, 1999; Orosz and Burns, 2000). This is also reflected in the health care expenditures ratio to GDP. For OECD countries on average, it remained flat between 1993 and 1998 (Table 1).

Health care expenditures started to rise again rapidly at the end of the 1990s and in the beginning of this decade, reflecting deliberate policies in some countries to relieve pressures arising from cost containment in previous years. An example in case is the policy of high real rates of increase over a number of years in the United Kingdom (Towse and Sussex, 2000). It seems that an observation made about the U.S. health care system might hold true for many other countries: "The wide range and sharp periodic cycles in spending growth produce disproportionate strains that contribute to the perception of a health system in constant crisis" (Altman et al., 2003).

Behind the average OECD growth rate there are wide variations, Table 2 shows the OECD countries in order of their health care expenditures growth rates. Several countries (e.g., Korea, Ireland, and Portugal) with lower income and lower health care expenditures per capita in 1990 experienced high growth in health care expenditures during the 1990s (Colombo and Hurst, 2002). As a result, they narrowed the gap with the OECD average both in terms of per-capita expenditure and health care expenditures share of GDP. At the beginning of this decade, health care

Figure 2

Health Care Expenditures as a Percent of Gross Domestic Product (GDP): 2001



NOTES: 2000, for Australia, Japan, Korea, and Luxembourg. For Germany, average annual growth rate is calculated for 1992-2001.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

expenditures per capita in these countries was 50-100 percent higher than in 1990 (Table 2). A few high-income countries (Japan, Australia, and United Kingdom) also experienced strong growth in health care expenditures over the past decade.

Ireland experienced high growth in both health care spending and GDP (6.8 and 6.4 percent per year), and consequently the share of health care expenditures in GDP increased only slightly. Despite the high growth in health care spending, there was only a modest increase in services. "It is important to recognize that a significant part of the increase is due to factors driving up the costs of health care without increasing the level of service provision" (Deloitte & Touche, 2001). The rapid growth of the Irish economy in the 1990s caused labor shortages in a number of sectors. This also put an upward pressure on labor costs in the health care sector, and led to significant real increases in average wages for all categories of health care staff.

The United Kingdom underfunding of the health care system resulted in growing dissatisfaction by the end of the 1980s. In 1991-1992, in order to oil the wheels of major health care reform, the Tory-government considerably increased public expenditure on health care (as an average

Table 2

Growth of Per Capita Expenditures on Health Care Compared to Gross Domestic Product (GDP) Growth, by Country: 1990-2001

Country	1990-2000 Real Annual Growth Rate		Ratio of Total Health Care Expenditures Growth to GDP Growth	2000-2001 Real Annual Growth Rate		2001 Real Per Capita Health Care Expenditures 1990=100
	GDP	Care Expenditures		GDP	Total Health Care Expenditures	
Korea	5.2	7.4	1.42	2.3	—	—
Ireland	6.4	6.8	1.06	4.2	5.7	203
Portugal	2.5	6.4	2.56	1.0	2.9	191
Poland	3.5	4.8	1.37	1.0	6.6	171
Greece	2.0	4.5	2.25	0.1	-0.7	154
United Kingdom	2.1	4.0	1.90	1.6	5.8	157
Czech Republic	0.2	3.9	19.50	4.1	6.4	156
Australia	2.4	3.8	1.58	2.5	—	—
Japan	1.1	3.8	3.45	0.1	—	—
Mexico	1.7	3.8	2.24	-1.7	16.5	169
Spain	2.4	3.5	1.46	1.8	2.7	145
Belgium	1.9	3.4	1.79	0.4	4.5	146
Iceland	1.6	3.1	1.94	1.7	0.5	136
Luxembourg	3.9	3.0	0.77	0.1	—	—
Netherlands	2.3	3.0	1.30	0.5	4.0	140
United States	2.0	3.0	1.50	-0.7	5.1	141
Norway	3.0	2.9	0.97	0.9	6.3	141
Austria	1.9	2.8	1.47	0.4	0.4	132
New Zealand	1.4	2.8	2.00	2.7	4.5	138
Switzerland	0.2	2.5	12.50	0.2	1.9	130
France	1.5	2.4	1.60	1.3	3.5	131
Germany (1992-2000)	1.2	2.1	1.75	0.4	1.7	130
Canada	1.8	1.9	1.06	0.3	6.2	129
Denmark	1.9	1.8	0.95	1.1	3.8	123
Sweden	1.6	1.8	1.13	0.8	4.7	126
Hungary (1991-2000)	2.5	1.7	0.68	4.1	5.5	—
Italy	1.4	1.6	1.14	1.7	4.6	122
Finland	1.7	0.1	0.06	0.4	4.6	106
Slovak Republic	—	—	—	3.5	3.4	—
OECD Average Countries (28)[1]	2.2	3.3	1.51	—	—	—
OECD Average Countries (24)[2]	2.0	3.1	1.53	1.2	4.5	—
European Union Average Countries[3]	2.2	3.2	1.44	1.1	3.4	—

[1] The average excludes the Slovak Republic and Turkey.

[2] The average excludes Australia, Japan, Korea, Luxembourg, Slovak Republic, and Turkey.

[3] The average includes Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

NOTES: For Germany, the average annual growth rate is calculated for the period of 1992-2001; for Hungary for 1991-2001. OECD is Organisation for Economic Co-operation and Development.

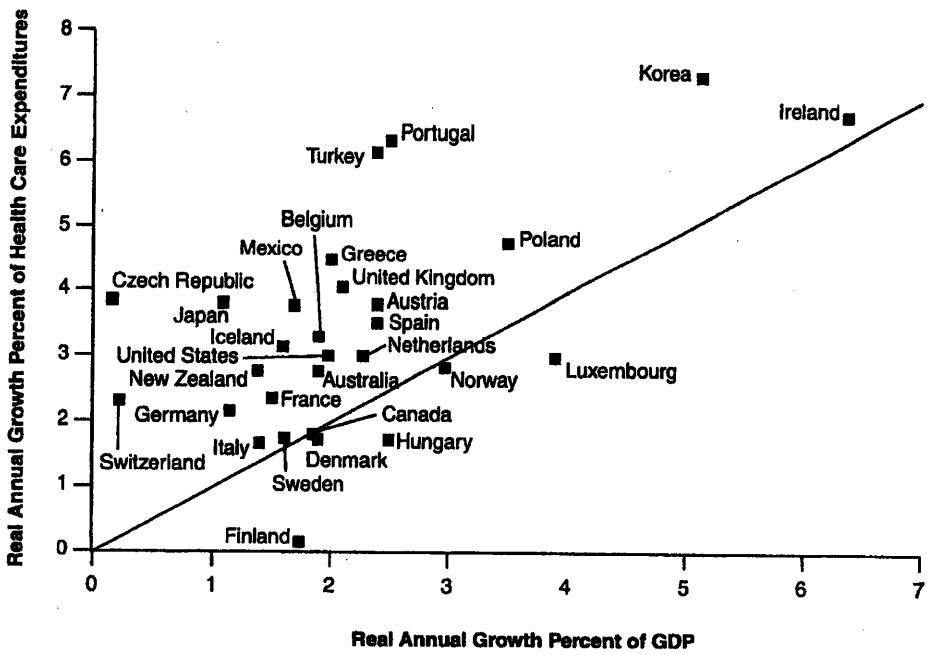
SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

by 5.2 percent). Total expenditure grew by 6.2 percent per year. Then, between 1992 and 1998, the government exerted a strong cost-containment policy again (Koen, 2000); and the growth rate of total health care expenditures was only 2.6 percent (which is below the OECD average). Since 2000, the Labour-government has given a higher priority to the national health statistics (NHS): In January 2000

Britain's Prime Minister declared there would be an increase in spending on the NHS in order to reach the European Union (EU) average measured by the proportion of GDP spent on health care by 2006 (Department of Health, 2000; Towse and Sussex, 2000; Ferriman, 2000). More recently, in mid-2002 after a review of the long-term trends affecting the NHS (Wanless, 2002) the Chancellor confirmed

Figure 3

Increase in Per Capita Health Care Expenditures and Gross Domestic Product (GDP): 1990-2000



SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

that there would be a 43-percent increase in real terms in health spending over the next 5 years (that is more than 7 percent annual average growth). A public service agreement published by the Department of Health outlined the improvements that patients could expect, including reduced waiting times for hospital outpatient appointments to maximum 3 months and inpatient appointments to 6 months by 2005 (Coomber, 2002).

On the other hand, 12 OECD countries had below-average health care expenditures growth during the past decade (Table 2). Among these countries two groups can be distinguished, taking into consideration GDP growth. In several countries (e.g., Switzerland, France, and Germany) health care expenditures still grew faster than the economy, resulting in a considerable increase in the ratio of health care spending to GDP (Table 1). In other countries, low health care expenditures growth between 1990 and 2000 went together with a similar or somewhat higher GDP growth, resulting in a decrease in the ratio of health care spending to GDP in Finland and Hungary and a stabilization of the ratio in Canada, Italy, and Sweden.

Table 2 shows the proportional gap in real growth rates of GDP and health care expenditures during the 1990s. In the U.S. it was 50 percent, which is close to the OECD average. It is interesting to note that while the real health care expenditures growth rate was slightly slower in the U.S. than in the EU during the 1990s (3.0 percent compared to 3.2 percent), the gap between health expenditure and GDP growth was somewhat higher in the U.S. (50 percent compared to 40 percent). However, at the beginning of this decade both real health care spending growth and

Table 3

Growth of Per Capita Expenditures on Health Care in Real Terms: 1970-2001

Country	1970-1980	1980-1990	1990-1992	1992-1997	1997-2001	1990-2001
			Percent Change			
Australia	5.2 (1969-1980)	2.6	3.1	3.9	4.0[a]	3.8
Austria	7.4	1.4	4.6	1.4	3.0	2.6
Belgium	8.1	3.4	4.7	2.7	3.9	3.5
Canada	3.2	4.0	3.5	-0.3	5.1	2.3
Czech Republic	—	—	-2.1	8.0	2.6	4.1
Denmark	2.9 (1971-1980)	0.8	0.3	1.7	3.0	1.9
Finland	4.6	4.8	2.0	-1.4	2.2	0.5
France	—	—	3.6	1.5	3.1	2.5
Germany	6.2	1.8	—	2.2	1.8	2.0(1992-2001)
Greece	4.5	1.3	4.4	5.0	2.5	4.0
Hungary	—	—	—	0.1	4.1	2.1(1991-2001)
Iceland	8.3	4.2	-0.6	1.8	5.9	2.8
Ireland	8.5	0.1	9.5	4.8	7.6	6.7
Italy	—	—	3.3	-0.4	4.0	1.9
Japan	7.1	2.6	4.0	3.4	14.2	3.8
Korea	—	—	5.8	7.1	19.0	7.4
Luxembourg	7.2	4.8	4.1	1.9	14.1	3.0
Mexico	—	—	11.3	0.4	7.4	4.9
Netherlands	—	2.3	3.6	1.5	4.9	3.1
New Zealand	2.1	2.9	1.5	2.6	4.2	3.0
Norway	9.1	3.1	5.6	3.2	2.1	3.2
Poland	—	—	9.1	3.9	4.4	5.0
Portugal	11.5	4.2	8.7	6.2	4.7	6.1
Slovak Republic	—	—	—	—	1.8	—
Spain	6.9	4.7	5.6	2.6	3.4	3.4
Sweden	4.4	1.1	-1.3	1.3	4.8	2.1
Switzerland	4.1	2.7	4.0	1.6	2.6	2.4
Turkey	—	3.6	3.5	5.2	—	6.1(1990-1998)
United Kingdom	4.1	3.2	6.3	2.8	4.9	4.2
United States	4.5	5.5	4.4	2.3	3.7	3.2
OECD Average Countries (28)[2]	NA	NA	4.2	2.6	4.2	3.4
OECD Average Countries (18)[3]	6.0	3.0	3.9	2.5	4.0	3.3

[1] For those countries not reporting 2001 figures the growth rates cover the period up to 2000.

[2] The average excludes the Slovak Republic and Turkey.

[3] The average excludes Belgium, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland, and Turkey.

NOTES: Real expenditures are adjusted for gross domestic product deflator. For Germany, the average annual growth rate is calculated for the period of 1992-2001; for Hungary for 1991-2001; and for Turkey for 1990-1998. OECD is Organisation for Economic Co-operation and Development. NA is not available. Numbers in parentheses are the number of countries that OECD had data for. Not all countries report data for the years shown in column headers. Where this is the case, closest available year, shown in parentheses for which data are available.

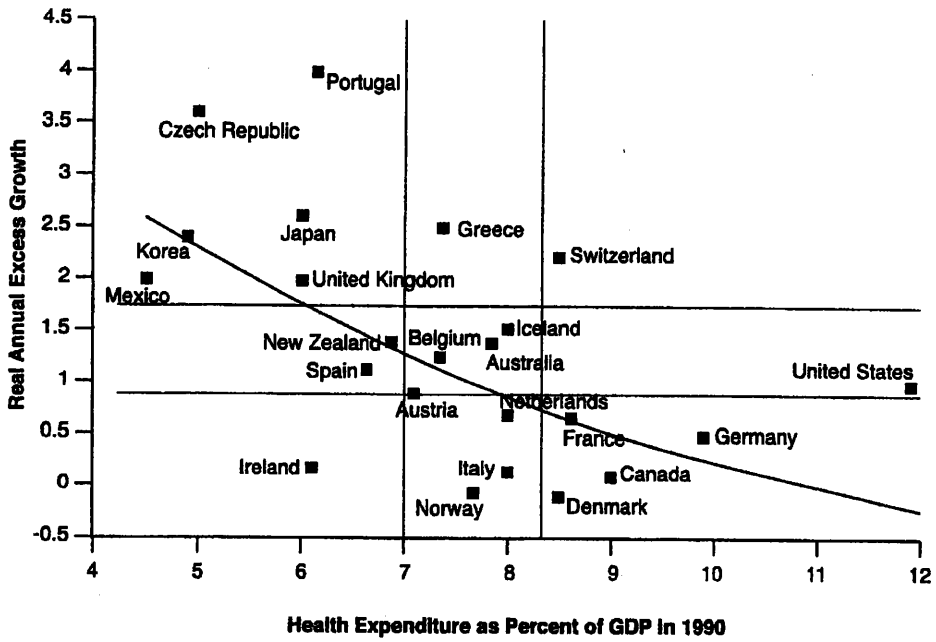
SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

the gap in growth rates in the U.S. has again considerably exceeded the EU average, and even the OECD average (Table 2).

The phenomenon of excess growth prevalent in countries whose health care expenditures ratio was relatively low in 1990 (Figure 4), has led to some convergence of expenditure ratios. This figure plots the excess growth of health over GDP with the share of health care expenditures in 1990, the beginning of the time period studied in this graph. Countries at the lower end of the health care expenditures ratios tend to have higher excess growth rates, whereas several countries at the higher end of the scale had low or no excess growth in health care spending over the GDP (for example, Denmark and Canada). This pattern is not unambiguous: the three countries with high expenditure ratios in 1990 (Germany, Switzerland, and the U.S.) had relatively high excess growth of health.

Figure 4

Excess Growth in Total Health Care Expenditures Per Capita: 1990-2000



NOTES: Data for solid lines show terciles of GDP growth and terciles of national health expenditures growth. Germany, 1992-2000.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

PER CAPITA EXPENDITURE ON HEALTH CARE

Health care expenditures per capita converted to US$ purchasing power parity (PPP)[7] is commonly used to compare the overall level of consumption of health care goods and services across countries. According to this measure, the U.S. continues to spend far more on a per capita basis for health care than any other country. It spent over US$4,880 per capita on health care in 2001—more than twice the average of around US$2,080 PPP across OECD countries (Figure 5). Next in this ranking for 2001 come Switzerland, Norway, Germany, and Canada; and at the other end of the scale, Mexico, Poland, Slovak Republic, Korea, and Hungary spent less than US$1,000 on health care.

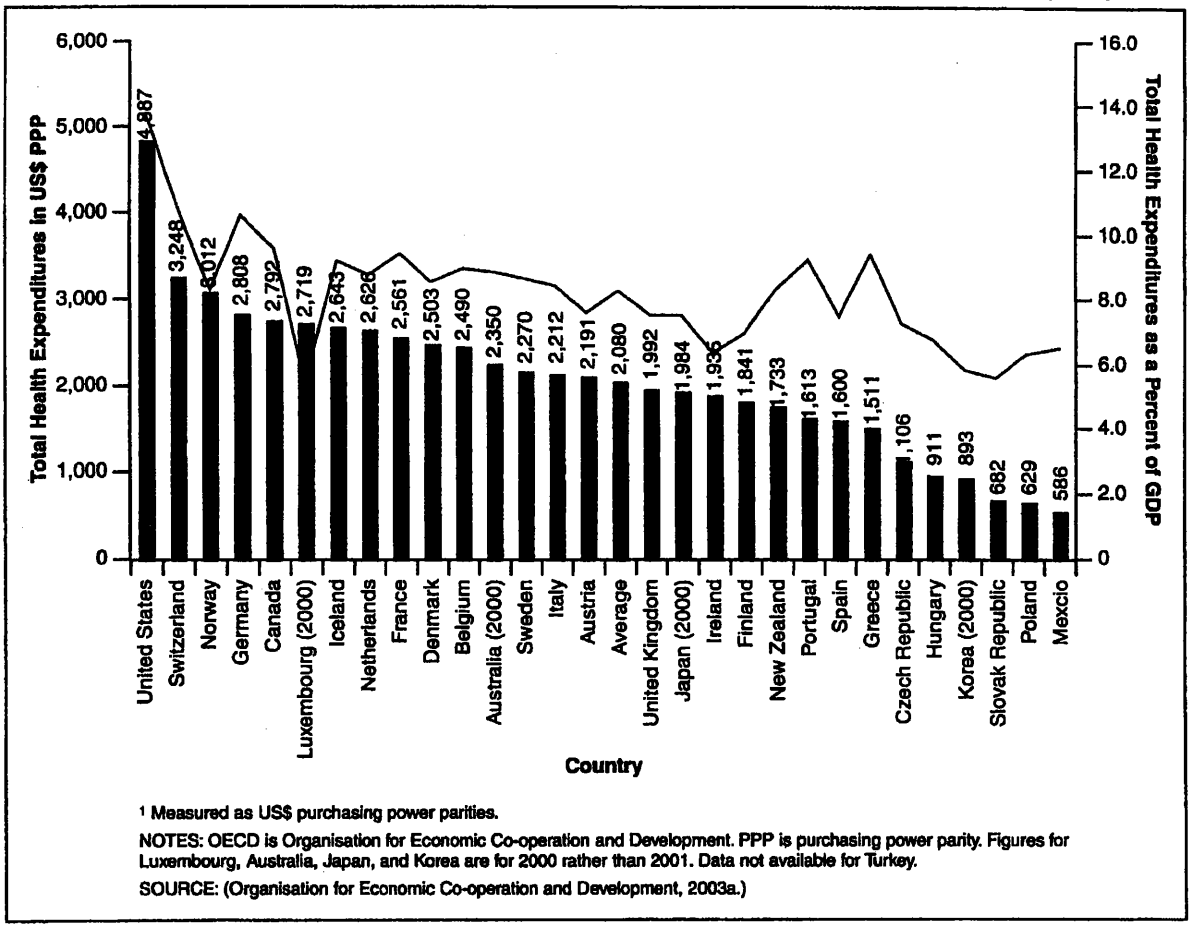
[7] PPP indexes are used to adjust spending levels to reflect the various countries' price level of a fixed basket of goods and services.

Figure 5 shows per capita expenditure and expenditure as share of GDP together. It is evident that differences in per capita values are far greater than in health care expenditures as percent of GDP. The figure also reflects that, depending on economic development, countries having a high share of health care expenditures to GDP ratio might have low per capita expenditure, and vice versa. For example, Greece and France both spent around 9.5 percent of GDP on health care, but health care expenditures per capita in France was 70 percent higher.

Differences in health care spending across countries are greater than differences in GDP per capita (Table 4). For instance, in 2001, GDP per capita in the U.S. was 40 percent higher than the OECD average, while expenditure on health care was 135 percent greater. Most of the lower

Figure 5

Total Health Care Expenditures Per Capita and as a Percent of Gross Domestic Product (GDP): 2001



[1] Measured as US$ purchasing power parities.

NOTES: OECD is Organisation for Economic Co-operation and Development. PPP is purchasing power parity. Figures for Luxembourg, Australia, Japan, and Korea are for 2000 rather than 2001. Data not available for Turkey.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

income OECD countries (Korea, Czech Republic, Hungary, Slovak Republic, Poland, Mexico, and Turkey) see greater deviations from the OECD average in relation to health care expenditures per capita than for GDP per capita. Over the past decade, however, the lower income OECD countries, with the only exception of Hungary, narrowed their gap from the OECD average, both in terms of total and public expenditure on health.

For OECD countries on average, the statistical significance of a simple regression relationship between growth rates in per capita health care spending and per capita GDP has declined during the 1990s (Huber, 1999). This can be seen with the help of the scatter diagram in Figure 3. If the cluster of countries that excludes the two outliers of Korea and Ireland (both saw exceptional health care expenditures and GDP growth during the 1990s) is studied separately, the correlation between GDP growth and health care expenditures growth is not significantly different from zero.[8]

Trends in Health Care Funding

In all countries, health care is financed through a mixture of publicly-funded benefits and services, private social provision (largely employer-sponsored social insurance, but also some cooperative mutual

[8] The R^2 equals 0.07 for a linear relationship for the reduced cluster. The R^2 measure is 0.36 if Korea and Ireland are included in the sample.

Table 4

Per Capita Gross Domestic Product (GDP) and Total Health Care Expenditures, by Country: 2001

Country	OECD Average=100 GDP	OECD Average=100 Total Health Expenditure	Per Capita US$ PPP Total Health Expenditure
OECD Average Countries[1]	100	100	$2,080
Luxembourg	194	131	2,719
Norway	146	145	3,012
United States	140	235	4,887
Ireland	120	93	1,935
Switzerland	119	156	3,248
Netherlands	117	126	2,626
Denmark	117	120	2,503
Iceland	115	127	2,643
Canada	115	134	2,792
Austria	113	105	2,191
Belgium	111	120	2,490
Australia	109	113	2,350
France	107	123	2,561
Japan	106	95	1,984
Finland	106	88	1,841
Italy	105	106	2,212
United Kingdom	105	96	1,992
Germany	105	135	2,808
Sweden	104	109	2,270
Spain	85	77	1,600
New Zealand	84	83	1,733
Portugal	70	78	1,613
Greece	64	73	1,511
Korea	63	43	893
Czech Republic	60	53	1,106
Hungary	54	44	911
Slovak Republic	48	33	682
Poland	40	30	629
Mexico	36	28	586
Turkey	23	—	—

[1] The average excludes Turkey.

NOTES: OECD is Organisation for Economic Co-operation and Development. PPP is purchasing power parity. Figures for Luxembourg, Australia, Japan, and Korea are for 2000 rather than 2001.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

insurance) and direct private purchase of medical services, pharmaceuticals and appliances, plus private voluntary insurance.

Public third-party payment arrangements are either expenditures from general government revenues or based on social insurance systems. Although the U.S. health care system is thought of as primarily privately funded (only about one-quarter of the U.S. population is insured through public programs), the U.S. ranks fourth in the OECD in terms of spending per-capita from public funds, behind Norway, Luxembourg, and Iceland (Docteur, Suppanz, and Woo, 2003).

Private sources of funding comprise out-of-pocket spending, private health insurance (often funded by employers and subsidies by tax exemption), and other private sources. These include direct health benefits such as occupational health care, or charities.

From the view of private households and individual health care consumers, an important boundary line is between out-of-pocket spending and all other health care funding, i.e., the part of health care provided under a third-party payment arrangement, which can be either a public or a private program. According to this definition, out-of-pocket spending includes both

Table 5

Health Care Expenditures Source of Funding, as a Percent of Total Health Expenditure, by Country: 1990 and 2000

Country	1990			2000		
	Public	Private	Out of Pocket	Public	Private	Out of Pocket
Australia	67	33	17	69	31	18
Austria	74	27	—	70	31	19
Belgium	—	—	—	71	28	—
Canada	75	26	14	71	29	16
Czech Republic	97	3	3	91	9	9
Denmark	83	17	16	83	18	16
Finland	81	19	16	75	25	20
France	77	23	11	76	24	10
Germany	76	24	11	75	25	11
Greece	54	46	—	56	44	—
Hungary (1991)	89	11	11	76	25	21
Iceland	87	13	13	84	16	16
Ireland	72	28	16	73	27	13
Italy	79	21	15	73	27	23
Japan	78	22	—	78	22	17
Korea	37	63	53	44	56	41
Luxembourg	93	7	5	88	11	8
Mexico	43	57	57	48	52	52
Netherlands	67	33	—	63	37	9
New Zealand	82	18	14	78	22	15
Norway	83	17	15	85	15	15
Poland	92	8	—	71	30	—
Portugal	66	35	—	69	32	—
Slovak Republic	—	—	—	89	11	11
Spain (1991)	79	21	19	72	28	24
Sweden	90	10	—	85	15	—
Switzerland	52	48	36	56	44	33
Turkey (1998)	61	39	—	72	28	—
United Kingdom	84	16	11	81	19	—
United States	40	60	20	44	56	15
OECD Average Countries (27)[1]	74	26	NA	72	28	NA
OECD Average Countries (19)[2]	73	27	19	72	28	20

[1] Excludes Belgium, Slovak Republic, and Turkey.

[2] Includes Australia, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Italy, Korea, Luxembourg, Mexico, New Zealand, Norway, Spain, Switzerland, and the United States.

NOTES: Total private includes private insurance, out-of-pocket and other private sources (companies, non-governmental organisations, etc). OECD is Organisation for Economic Co-operation and Development. NA is not available. Figures for Hungary and Spain are for 1991 rather than 1990; and for Turkey for 1998 rather than 2000.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

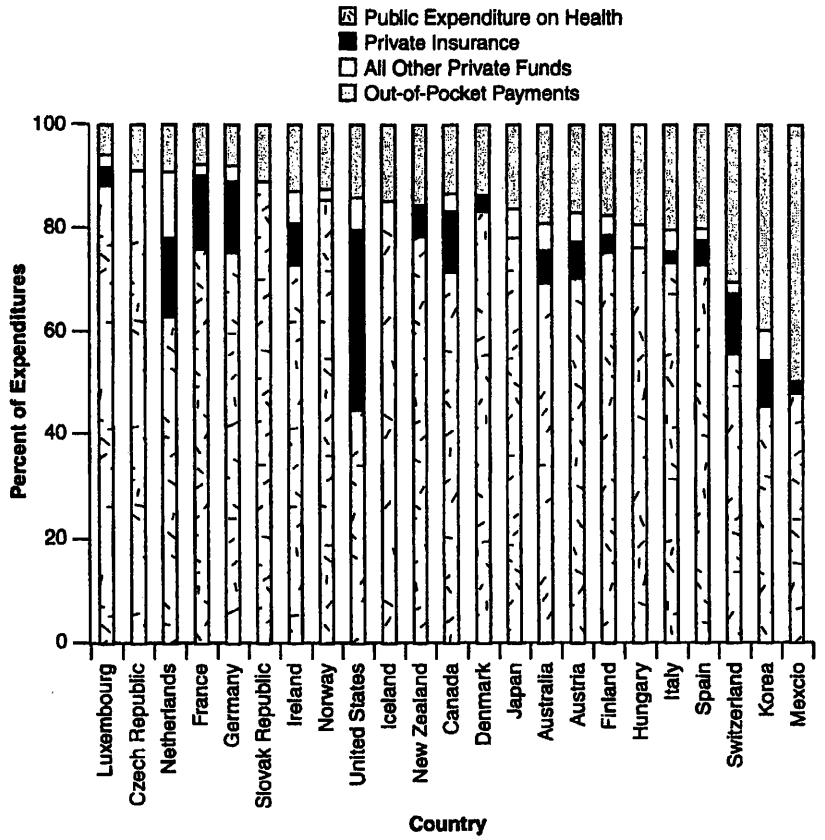
over-the-counter and similar direct payment to providers that are not refundable, plus cost sharing of private households. This includes the funding of services and medical goods that are (at least partially) covered under a third-party payment program.

Figure 6 shows how OECD countries are ranked by their increasing share of out-of-pocket spending and by total health care expenditures. The public sector is the main source of health care funding in all OECD countries, except the U.S., Mexico, and Korea. During the 1970s, the public share of health care spending increased in OECD countries on average, but since 1980 has stabilized and even slightly declined in the 1990s. On average, the public share of health care funding accounted for 72 percent in 2001. The public share was more than 80 percent in several countries, including the Czech Republic, Denmark, and the United Kingdom (Table 5 and Figure 6).

The share of out-of-pocket payments was above 30 percent of total health care expenditures in Switzerland, Korea, and Mexico. It varies between 10 and 30 percent of total

Figure 6

Health Care Expenditures[1], by Source of Funding: 2000



[1] Countries are ranked by their increasing share of out-of-pocket spending.

NOTE: Not all countries have this data available.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

health care expenditures for most countries with available data (Table 5). With a few exceptions, there is a tendency for the share of out-of-pocket spending to decline as health care expenditures per capita rises.

Out-of-pocket spending on health care continues to be among the most dynamic components of private consumption in a majority of OECD countries. There are substantial differences between countries in the baskets of goods and services that are paid out of pocket. Pharmaceuticals are one of the major components in all countries. However, countries differ markedly in the share of private spending that is devoted to services, such as denture and long-term care (LTC) in nursing homes and home-help services, also reflecting differences in public coverage of these items.

There is complementarity between public spending and private insurance in several countries. Private insurance can provide both basic coverage for those not covered by public systems or provide complementary insurance for specific services or that part of service cost not covered under public programs. Examples of the first type of private insurance include employer-sponsored private insurance group contracts in the U.S. and private insurance contracts of state employees in Germany. Complementary health care insurance is a

Table 6

Out-of-Pocket Payments for Health Care as a Percent of Total Household Consumption of All Goods and Services, by Country: 1990 and 2000

Country	1990	2000
Australia	2.2	2.7
Austria	—	2.7
Belgium	—	—
Canada	2.4	2.7
Czech Republic	0.3	1.2
Denmark	2.8	2.8
Finland	2.5	2.9
France	1.8	1.8
Germany	1.8	2.0
Greece	—	—
Hungary (1991)	1.5	2.8
Iceland	1.8	2.6
Ireland	1.8	1.9
Italy	2.1	3.1
Japan	—	2.3
Korea	4.9	4.3
Luxembourg	0.7	1.1
Mexico	3.7	4.3
Netherlands	—	1.6
New Zealand	1.7	2.1
Norway	2.4	2.7
Poland	—	—
Portugal	—	—
Slovak Republic	—	1.1
Spain (1991)	2.2	3.0
Sweden	—	—
Switzerland	5.5	6.1
Turkey	—	—
United Kingdom	1.1	—
United States	3.6	2.9
OECD Average Countries (19)[1]	2.4	2.8

[1] Includes Australia, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Italy, Korea, Luxembourg, Mexico, New Zealand, Norway, Spain, Switzerland, and the United States.

NOTE: Figures for Hungary and Spain are for 1991 rather than 1990.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

common way of financing dental and medical appliances, or privately paid upgrades of hospital accommodation.

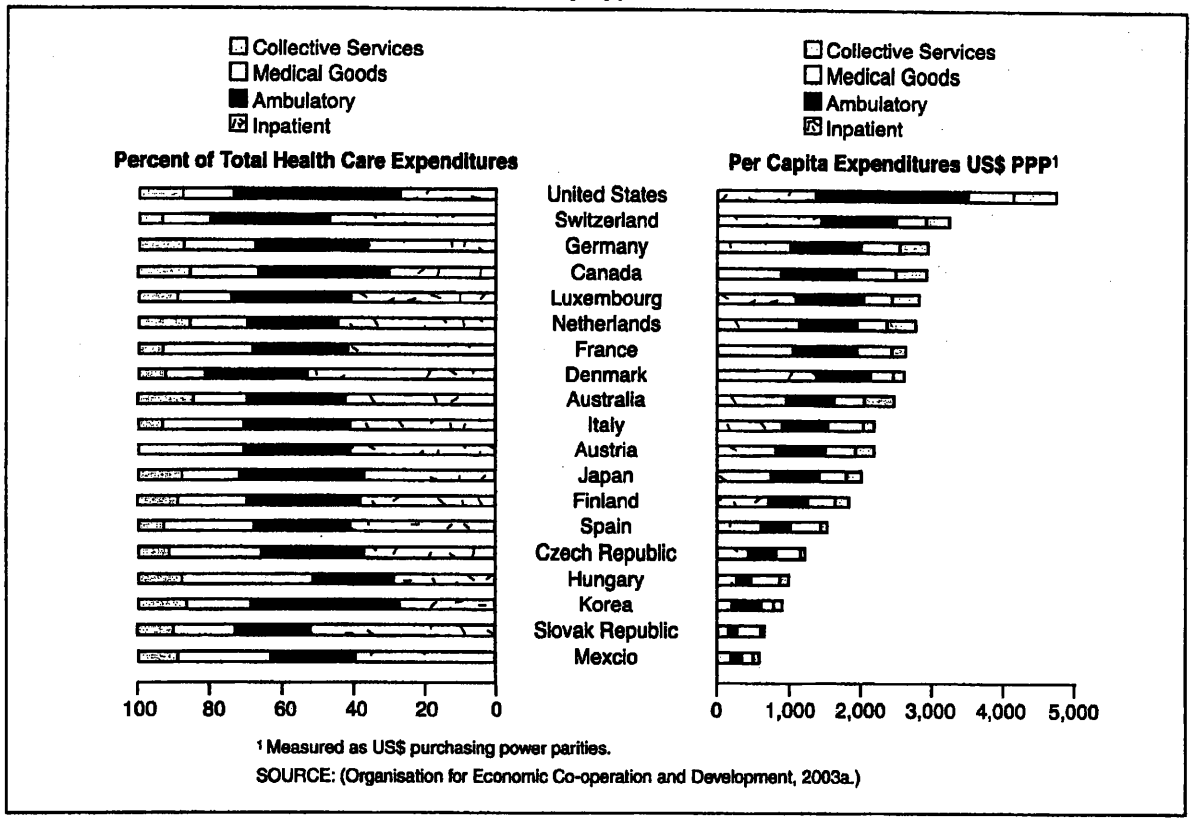
Data for a number of countries suggest that out-of-pocket spending for health care rose as a share of total household consumption during the 1990s (Table 6). Of the 19 OECD countries for which this measure is available, all but 4 experienced such an increase; the share remained constant in Denmark and France, and decreased in Korea and the U.S.

TYPE OF SERVICE EXPENDITURE

OECD countries differ in the ways health care expenditures are allocated according to type of service provided and medical goods consumed (Figure 7). In 2001, on average across OECD countries, 38 percent of total health care expenditures was allocated to inpatient care, 31 percent for ambulatory services (including ancillary services and home care), 21 percent for medical goods (including pharmaceuticals and medical appliances) and the remaining 10 percent was spent on collective services (administration and general public health prevention programs). But there are significant differences among countries. For example, Denmark, the Netherlands, and Switzerland allocated 45 percent or more of their health care expenditures on inpatient care in 2001, while countries such as the U.S. and Canada

Figure 7

Health Care Expenditures, by Type of Service Provision: 2001



1 Measured as US$ purchasing power parities.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

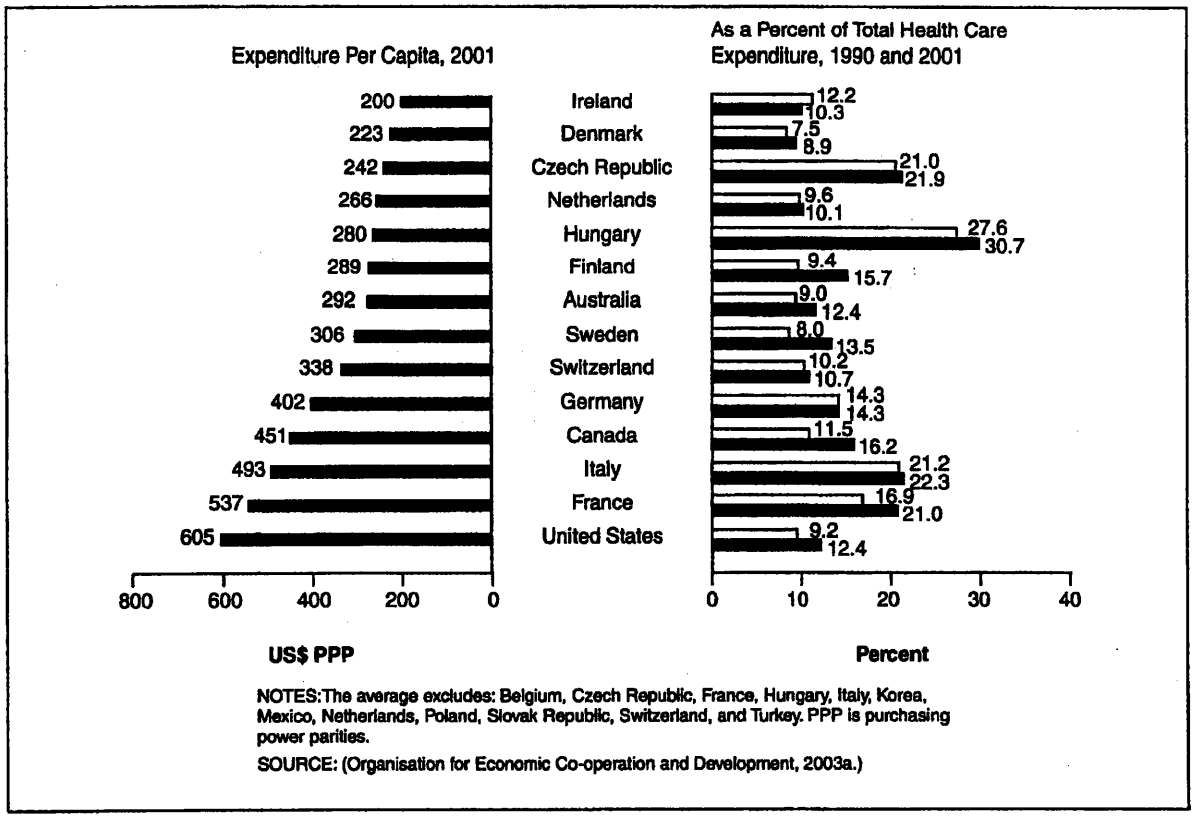
spent less than 30 percent on this component of their health care system (Figure 7). Hungary and the Slovak Republic spent almost 40 percent of their total health care expenditures on medical goods (including pharmaceuticals, such as prescription drugs), while Denmark, Switzerland, and the U.S. spent less than 15 percent on this item.

Figure 7 shows that the relative shares of types of services in overall spending can refer to quite different absolute spending levels in countries. For example, Hungary and the U.S. each spent roughly the same share of their health care expenditures on inpatient care, but in dollar terms the U.S. spent 5.2 times more then Hungary did. Similarly, Hungary devoted 30 percent of its health care expenditures to medical goods, compared to 12 percent in the U.S., but dollar spending in the U.S. was 2.1 times that in Hungary (Figure 7). In fact, the relatively small share of pharmaceutical spending in the U.S. corresponds to the highest per-capita spending in the OECD (Figure 8).

Reasons for international differences in the distribution of expenditures among provider types can be traced back to several roots. Constant changes and innovation in medical technology, reforms in payment mechanisms, and the search for more efficient allocation of health care resources all act together over time to modify the division of labor in health care across provider industries. This involves complex trends in specialization and integration, increasing the need for better coordination to bring basic services closer to consumers in the community.

Figure 8

Pharmaceutical Expenditures Per Capita, and as a Percent of Total Health Care Expenditures: 1990-2001



NOTES:The average excludes: Belgium, Czech Republic, France, Hungary, Italy, Korea, Mexico, Netherlands, Poland, Slovak Republic, Switzerland, and Turkey. PPP is purchasing power parities.

SOURCE: (Organisation for Economic Co-operation and Development, 2003a.)

CHANGING ROLE OF PHARMACEUTICAL SPENDING

Pharmaceutical products represent an important and growing share of health care expenditures in most countries. The number of new drugs increased considerably during the past decade, and the movement toward new, more expensive products has been one of the main driving forces in increasing pharmaceutical expenditure, thereby contributing to the increase in overall health care spending. There are considerable differences in pharmaceutical spending across countries, reflecting differences in volume, structure of consumption, and price level. The U.S. spends the most on pharmaceuticals, with expenditure per capita of US$605 PPP in 2001. France, Italy, Canada, and Germany followed the U.S., with spending of more than US$400 PPP per capita (Figure 8).

On average the annual growth rate of pharmaceutical expenditure was 30 percent higher than that of total health care expenditures during the 1990s resulting in increasing shares of pharmaceuticals in total spending (Figure 8) (Organisation for Economic Co-operation and Development, 2003b). OECD countries at the lower end of the income scale tend to spend a greater share of their health care expenditures on pharmaceuticals, partly because pharmaceuticals have international market prices while labor costs are usually based on national wage structures. For example, Hungary and the Slovak Republic spent around 30 percent of total health care

expenditures on pharmaceuticals, while Denmark and the Netherlands spent around 10 percent. The share spent on pharmaceuticals can also be very different in countries having similar health care spending per capita. For example, Denmark spends 9 percent of total health care expenditures on pharmaceuticals while France spends 21 percent (Figure 8), although both have roughly the same total health care spending per capita (Figure 7).

Pharmaceutical expenditure tends to be funded from private sources to a greater extent than inpatient and outpatient services, because copayments tend to be higher on pharmaceuticals and a considerable portion of pharmaceuticals are not covered under public insurance schemes (Organisation for Economic Co-operation and Development, 2003b).

Most OECD countries have been applying a mix of tools to try to control pharmaceutical expenditures over the past two decades. Increased cost sharing for pharmaceuticals has been a common feature (Mossialos, and Le Grand, 1999; Saltman and Figueras, 1997). The number of drugs not reimbursed has increased, mainly comfort drugs or those without proven therapeutic value. The degree of cost sharing has been increased for many others. In a number of cases, flat-rate payments per prescription have been established. Reference price systems have also been introduced in several countries (e.g., Germany, Denmark, and the Netherlands). These arrangements increase cost sharing for individuals using high-cost products while promoting the use of less-costly generic drugs.

REVISIONS OF HEALTH EXPENDITURE ESTIMATES

The reporting on trends in health care spending across countries in a timely, comparable, and policy relevant way needs a constant investment both by the international community and by individual countries to keep national reporting systems up-to-date with rapidly changing health care systems, and to ensure that a core set of expenditure indicators can be reported in an internationally harmonized way for comparative purposes. To facilitate this process, the OECD Secretariat has published an accounting framework which is now used by an increasing number of OECD member and non-member countries (Organisation for Economic Co-operation and Development, 2000).[9]

OECD member countries are currently at different stages of implementing the SHA manual, and/or of harmonizing their reporting on health care expenditures according to main categories and definitions of the International Classification of Health Accounts (ICHA) as proposed by the SHA (Organisation for Economic Co-operation and Development, 2002). In several countries, the reporting on health care accounts according to the SHA framework is now part of national reporting (e.g., Denmark, Germany, Hungary, Japan, Korea, Mexico, Netherlands, and Switzerland).[10] Other countries produce estimates according to the OECD framework, but mainly for purposes of reporting to the OECD health care data collection (e.g., Australia, Canada, France, and the U.S.) and detailed results and comments on estimation methods are made available with the description of the national data sources and estimation methods (Organisation for Economic Co-operation and Development, 2003a). Comparability of data is still restricted for countries

[9] The spread of core concepts and classifications of the System of Health Accounts (SHA) manual in non-OECD countries has recently been boosted by the publication of a *Guide to Producing National Health Accounts with Special Applications for Low-Income and Middle-Income Countries* (World Bank, World Health Organisation, and United States Agency for International Development, 2003).

[10] The country lists may not be exhaustive as they only provide a snapshot picture as of summer 2003. The actual status of SHA projects in countries may change quickly, depending on available resources in statistical agencies for work on this task.

where SHA pilots are at an early or experimental stage (e.g., Finland, and the United Kingdom), and where the SHA implementation has not been started (e.g., Austria, , Italy, Portugal, and New Zealand).

But even where results of the detailed tables of the SHA framework are not yet available publicly, some experience with the SHA manual has now been gained in at least 25 of the 30 OECD countries. During this process, statisticians have re-examined their overall expenditure estimates and the basic breakdown according to various dimensions (type of services and goods, industries of providers, and sources of financing). They have also conducted an inventory of available sources for more detailed estimates. As these more detailed estimates are being implemented in a growing number of countries, comparability of health care expenditures estimates is expected to constantly improve in the future.

As a result of this work, the main issues of comparability are now well known. Two of the most significant are the boundary between health care and other social services, in particular for older persons in need of LTC, and the structure and amount of spending from a multitude of private sources. For example, a better estimate of LTC increased the estimate for total expenditure in Sweden by 7.7 percent in 2001. (It meant that the new estimate for total expenditure as a percentage of GDP was 8.7 percent, compared to 8.0 percent before adjustment for LTC.[11]) The OECD Secretariat currently conducts in-house research on both issues in the framework of a project on LTC policies, and a project on private health insurance (Organisation for Economic Co-operation and Development, 2003a).

[11] OECD data has been revised for Sweden back to 1993.

CONCLUSIONS

There are initial reports from several countries that the trend of accelerated growth is continuing in 2002, which once again brings the discussion of the limits of health care spending growth to the forefront of public policy debate (e.g. Canada, France, Germany, and the U.S.). Evidence of growing health care expenditures ratios has come from preliminary results of national health accounts for Canada, France, and the U.S. (Canada Institute for Health Information, 2003; Fénina and Geoffroy, 2003; Heffler et al., 2003), or from public spending trends that exceed expected GDP growth (German Federal Ministry of Health and Social Security, 2002).

Despite a general convergence of countries' experience over the past decade, the U.S. remains significantly different. The U.S. started the decade with a substantially higher level than other OECD countries—both in absolute terms in per-capita PPP, and as a percent of GDP. During the 1990s, real annual health care spending growth in the U.S. was compared to that of other OECD countries and to the EU average (Table 2). However, the 2000-2001 real health care spending growth in the U.S. was considerably above the EU average, and even the OECD average. In 2001, the U.S. spent more on health care by 2 percentage points of GDP than in 1990 (13.9 percent of GDP compared to 11.9 percent), while on average the EU spent more on health care by less than 1 percentage point of GDP (8.5 percent of GDP compared to 7.6 percent).

In order to present a more complete story about value-for-money that the health care dollar buys, the data presented in this

article need to be complemented by additional indicators. It is access to quality services and the ability of a health care system to build confidence that these will be provided in efficient and effective ways, that determine a society's willingness to dedicate a growing share of its overall resources to health care.

In order to be able to suggest how close an OECD country comes to its individual ideal in this respect, more and better data are needed on a macro level. In addition, substantially more work is needed on a more disaggregated level, but in ways that lead to internationally comparable results (Cutler, 2002).

On the aggregate level, work is currently undertaken at the OECD Secretariat to complement the currently available spending data by a more detailed breakdown of spending by type of service. This will help answer questions such as: to what extent is a relatively generous coverage—and high spending—of LTC services (for older persons, but also for younger adults) a common feature of several of the highest spending countries (e.g., in Canada, Germany, and Switzerland)?

An important part of the expenditure story is differences in prices, for both input and output of health-service provision (especially pharmaceutical prices and labor costs). Part of this task, such as a basic data set for comparing income of health professions is also currently on the OECD agenda and can be found at http://www.oecd.org/health. This will help in the future to be better able to decide to which degree differences in health expenditure are due to price differences (Anderson et al., 2003).

There is some evidence that differences in the availability of resources devoted to health care, which are also behind differences in expenditure, have an effect on outcomes (Or, 2000). Countries operating all or parts of their health care system with tightly controlled resources (for example, the hospital sector) may experience waiting lists that are increasingly seen as problematic (Hurst and Siciliani, 2003). On a semi-aggregate level, the spread of technology has been linked to expenditure growth (Moïse, 2003).

Finally, many questions on the relative efficiency of health care provision across countries can only be answered by detailed analysis using data on a much more disaggregated level, such as comparisons based on how certain health problems are tackled (treatment of diseases). The tentative conclusion from this type of study seems again to be that there is indeed some evidence that patients in the highest spending countries have some benefit from relative high spending (Organisation for Economic Co-operation and Development, 2003c). The main challenge for further work remains to build better data bridges between microdata and macrodata on health care activities, to find out more information about the most effective ways to spend additional health dollars and to understand better how technological progress contributes to both increasing cost and improved outcomes.

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C

TRENDS

Health Spending Rebound Continues In 2002

Once again, hospital spending drives total health spending upward.

by Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team

ABSTRACT: U.S. health care spending climbed to $1.6 trillion in 2002, or $5,440 per person. Health spending rose 8.5 percent in 2001 and 9.3 percent in 2002, contributing to a spike of 1.6 percentage points in the health share of gross domestic product (GDP) since 2000. Hospital spending accounted for nearly a third of the aggregate increase. During the past three decades, per enrollee spending for a common benefit package has grown at a slightly slower average annual rate for Medicare than for private health insurance, with more pronounced growth differences recently reflecting legislated Medicare reimbursement changes and consumers' calls for more loosely managed care.

GROWTH IN HEALTH SPENDING rose from 8.5 percent in 2001 to 9.3 percent in 2002, advancing much faster than the rest of the U.S. economy for the second consecutive year. It rose at more than twice the rate of growth of gross domestic product (GDP, 3.6 percent), causing health spending's share of GDP to rise from 13.3 percent in 2000 (where it had remained largely unchanged since 1993) to 14.1 percent in 2001 and 14.9 percent by 2002. Aggregate health spending climbed to $1.6 trillion, or $5,440 per person (Exhibit 1). After overall health expenditures are adjusted for economywide inflation, constant-dollar growth rose 7.1 percent per capita in 2002, compared with 4.9 percent average annual growth over the past four decades (Exhibit 2).

Private sources accounted for more than half of the $132.3 billion growth in health spending in 2002, as private health insurance payments rose $54.0 billion and direct payments from consumers rose $12.0 billion. Private health insurance alone contributed the largest share of the increase in 2002, 41 percent, while out-of-pocket spending contributed 9 percent, and other private funding accounted for 4 percent.[1] In the public sector, growth in the Medicaid program accounted for 20 percent of the overall increase as more people became eligible for enrollment. Other public funding accounted for 26 percent of overall health spending growth.

From the health care provider perspective, spending growth also reflected a return to higher growth in hospital care. Hospitals' contribution to aggregate spending has rebounded, as hospital spending growth rose from an average annual rate of 3.7 percent between 1993 and 2000, to 7.5 percent in 2001, and 9.5 percent in 2002. This service comprised 28 percent of the aggregate spending increase in 2001 and 32 percent in 2002 (Exhibit 3), approximately equal to its share of total spending. However, preliminary hospital employment data for 2003 indicate that demand

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EXHIBIT 1
National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1970–2002

Spending category	1970	1980	1988	1993	1997	2000	2001	2002
NHE, billions	$73.1	$245.8	$558.1	$888.1	$1,092.8	$1,309.4	$1,420.7	$1,553.0
Health services and supplies	67.3	233.5	535.4	856.3	1,055.5	1,261.4	1,370.0	1,496.3
Personal health care	63.2	214.6	493.3	775.8	959.2	1,135.3	1,231.4	1,340.2
Hospital care	27.6	101.5	209.4	320.0	367.6	413.2	444.3	486.5
Professional services	20.7	67.3	176.3	280.7	352.2	426.5	464.3	501.5
Physician and clinical services	14.0	47.1	127.4	201.2	241.0	290.3	315.1	339.5
Other professional services	0.7	3.6	14.3	24.5	33.4	38.8	42.6	45.9
Dental services	4.7	13.3	27.3	38.9	50.2	60.7	65.6	70.3
Other personal health care	1.3	3.3	7.3	16.1	27.7	36.7	40.9	45.8
Nursing home and home health	4.4	20.1	48.9	87.6	119.6	125.5	132.8	139.3
Home health care[a]	0.2	2.4	8.4	21.9	34.5	31.7	33.7	36.1
Nursing home care[a]	4.2	17.7	40.5	65.7	85.1	93.8	99.1	103.2
Retail outlet sales of medical products	10.5	25.7	58.7	87.5	119.8	170.1	190.0	212.9
Prescription drugs	5.5	12.0	30.6	51.3	75.7	121.5	140.8	162.4
Durable medical equipment	1.6	3.9	8.7	12.8	16.2	17.7	18.2	18.8
Other nondurable medical products	3.3	9.8	19.4	23.4	27.9	30.8	31.0	31.7
Program administration and net cost of private health insurance	2.8	12.1	26.6	53.3	60.9	80.3	90.3	105.0
Government public health activities	1.4	6.7	15.5	27.2	35.4	45.8	48.3	51.2
Investment	5.7	12.3	22.7	31.8	37.2	48.0	50.6	56.7
Research[b]	2.0	5.5	10.8	15.6	18.7	28.8	31.5	34.3
Construction	3.8	6.8	11.9	16.2	18.5	19.2	19.2	22.4
Population (millions)	210.2	230.4	248.9	262.6	272.7	280.4	282.9	285.5
NHE per capita	$348	$1,067	$2,243	$3,381	$4,007	$4,670	$5,021	$5,440
GDP, billions of dollars	$1,040	$2,796	$5,108	$6,642	$8,318	$9,825	$10,082	$10,446
NHE as percent of GDP	7.0%	8.8%	10.9%	13.4%	13.1%	13.3%	14.1%	14.9%
Chain-weighted GDP index	29.1	57.1	80.2	94.1	102.0	106.9	109.4	110.7
Real GDP, billions of dollars	$3,579	$4,900	$6,368	$7,063	$8,159	$9,191	$9,214	$9,440
Real NHE[c], billions of dollars	$251.5	$430.8	$695.7	$944.2	$1,071.9	$1,225.0	$1,298.4	$1,403.4
Personal health care deflator[d]	17.7	37.7	67.9	90.2	102.1	110.8	115.1	119.6

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

[a] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

[b] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

[c] Deflated using GDP chain-type price index (1996=100.0).

[d] Personal health care (PHC) chain-type index is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

for overall hospital services might be easing.[2]

Continued acceleration of health spending—without a similar increase in economic growth—threatens the affordability and generosity of sponsored health care benefits. Sustained weakness in the job market resulting in the loss of coverage also could shift some of the growing health care burden to the jointly funded federal-state Medicaid programs.

Sources Of Funds

In 2002 the share of spending paid through state and federal Medicaid programs (16 percent) nearly matched that of Medicare (17 per-

EXHIBIT 2
National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 1970–2002

Spending category	1970[a]	1980[b]	1988[b]	1993[b]	1997[b]	2000[b]	2001	2002
NHE	10.6%	12.9%	10.8%	9.7%	5.3%	6.2%	8.5%	9.3%
Health services and supplies	10.4	13.2	10.9	9.8	5.4	6.1	8.6	9.2
Personal health care	10.5	13.0	11.0	9.5	5.5	5.8	8.5	8.8
Hospital care	11.7	13.9	9.5	8.8	3.5	4.0	7.5	9.5
Professional services	9.5	12.5	12.8	9.8	5.8	6.6	8.8	8.0
Physician and clinical services	10.1	12.9	13.2	9.6	4.6	6.4	8.6	7.7
Other professional services	6.6	17.1	18.8	11.4	8.1	5.1	9.9	7.6
Dental services	9.1	11.1	9.4	7.3	6.6	6.6	8.0	7.2
Other personal health care	7.2	10.0	10.5	17.2	14.5	9.8	11.3	12.1
Nursing home and home health	17.2	16.3	11.8	12.4	8.1	1.6	5.8	4.9
Home health care[c]	14.5	26.9	17.1	21.0	12.1	-2.8	6.2	7.2
Nursing home care[c]	17.4	15.4	10.9	10.2	6.7	3.3	5.7	4.1
Retail outlet sales of medical products	7.8	9.4	10.9	8.3	8.2	12.4	11.7	12.0
Prescription drugs	7.5	8.2	12.4	10.8	10.3	17.1	15.9	15.3
Durable medical equipment	9.7	8.9	10.7	8.0	6.0	3.2	2.3	3.3
Other nondurable medical products	7.4	11.4	8.9	3.9	4.4	3.4	0.8	2.3
Program administration and net cost of private health insurance	8.6	15.9	10.3	15.0	3.4	9.7	12.5	16.2
Government public health activities	13.2	17.4	11.0	11.9	6.8	8.9	5.5	5.9
Investment	12.9	7.9	8.0	7.0	4.0	8.8	5.5	11.9
Research[d]	10.9	10.8	8.9	7.6	4.7	15.4	9.4	8.9
Construction	14.1	6.1	7.2	6.4	3.4	1.2	-0.3	16.8
Population	1.2	0.9	1.0	1.1	0.9	0.9	0.9	0.9
NHE per capita	9.3	11.9	9.7	8.6	4.3	5.2	7.5	8.3
GDP	7.0	10.4	7.8	5.4	5.8	5.7	2.6	3.6
Chain-weighted GDP index	2.7	7.0	4.4	3.2	2.0	1.6	2.4	1.1
Real GDP	4.2	3.2	3.3	2.1	3.7	4.0	0.2	2.4
Real NHE[e]	7.7	5.5	6.2	6.3	3.2	4.6	6.0	8.1
Personal health care deflator[f]	3.9	7.9	7.6	5.8	3.2	2.8	3.8	3.9

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

[a] Average annual growth, 1960–1970.

[b] Average annual growth from prior year shown; represents average growth over several years.

[c] Freestanding facilities only. Additonal services of this type are provided in hospital-based facilities and counted as hospital care.

[d] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

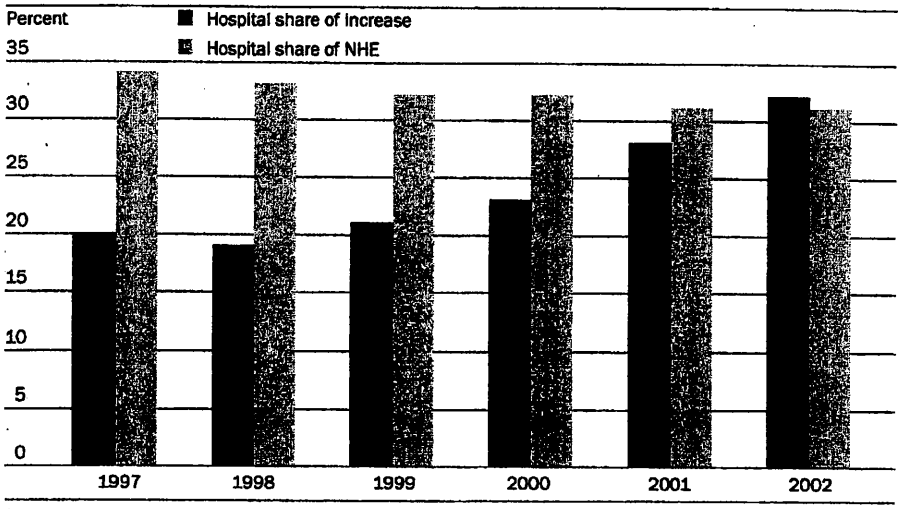
[e] Deflated using GDP chain-type price index (1996=100.0).

[f] Personal health care (PHC) chain-type index is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

cent). Medicaid's share has increased slowly over time, by an average 0.5 percentage points per year since 1989, as programs expanded to cover larger portions of the uninsured population. Medicare's share declined from a 19 percent peak in 1997 to 17 percent in 2002.

■ **Medicare.** Much of the variation in the public spending trend in recent years can be attributed to changes in Medicare, a federal program that accounted for $267 billion in payments to health care providers and for administrative costs in 2002 (Exhibit 4). Recent

EXHIBIT 3
Hospitals' Share Of Annual Spending Increase And Of National Health Expenditures (NHE), 1997–2002



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

trends in Medicare spending have been volatile: The Balanced Budget Act (BBA) of 1997 contributed to a rapid deceleration of spending growth in 1998 and 1999, followed by a rebound as the provisions of the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefit Improvements and Protection Act (BIPA) of 2000 were implemented. These acts primarily affected hospitals, nursing homes, and home health agencies. Recent legislation had the effect of lowering coinsurance for hospital outpatient services, reducing out-of-pocket spending for Medicare eligibles as it correspondingly raised Medicare spending. Medicare's most recent peak in growth occurred in 2001, as Medicare spending grew 9.5 percent (more than triple its average pace in 1997–2000) before slowing to 8.4 percent in 2002, when the formula for physician fee schedule payments was modified and provisions of BIPA expired.

Against a backdrop of a large cohort of baby boomers reaching Medicare eligibility over the next decade and projected depletion of the Hospital Insurance Trust Fund by 2026, the debate continues on how to structure the Medicare program (including coverage of prescription drugs) and the potential role of the private sector.[1] This debate often turns to comparisons of Medicare and private-sector spending trends, sometimes using data from the National Health Accounts (NHA). On a per enrollee basis, Medicare spending has grown at an average annual rate that was two percentage points slower than growth in private health insurance spending during the past three decades (Exhibit 5). This is attributable in part to Medicare's lack of coverage for outpatient prescription drugs. However, when one compares spending only for benefits provided by both Medicare and private health insurance (hospital, physician, clinical, and other professional services, plus durable medical products) from 1969 through 2002, Medicare's per enrollee spending has grown at a slightly slower average annual rate than private health insurance, with more pronounced differences in growth occurring after 1985. Between 1970 and 1985 average annual per enrollee growth rates for these benefits were similar. Since 1985, when Medicare implemented the first prospective payment system

EXHIBIT 4
National Health Expenditures (NHE), Amounts And Average Annual Percentage Growth, By Source Of Funds, Selected Calendar Years 1970–2002

Source of funds	1970[a]	1980[b]	1988[b]	1993[b]	1997[b]	2000[b]	2001	2002
NHE, billions	$73.1	$245.8	$558.1	$888.1	$1,092.8	$1,309.4	$1,420.7	$1,563.0
Private funds	45.4	140.9	331.7	497.7	589.2	714.9	768.4	839.6
Consumer payments	40.6	126.4	293.8	445.0	522.2	641.9	696.1	762.1
Out-of-pocket payments	25.1	58.2	118.9	146.9	162.1	192.6	200.5	212.5
Private health insurance	15.5	68.2	174.9	298.1	360.1	449.3	495.6	549.6
Other private funds	4.8	14.5	37.9	52.7	67.0	72.9	72.3	77.5
Public funds	27.6	104.8	226.4	390.4	503.6	594.6	652.3	713.4
Federal	17.6	71.3	154.1	274.4	360.2	416.0	460.3	504.7
Medicare	7.7	37.4	89.0	148.3	209.5	225.1	246.5	267.1
Medicaid[c]	2.8	14.5	31.0	76.8	94.8	118.4	132.0	147.5
Other federal[d]	7.1	19.4	34.1	49.3	55.8	72.5	81.7	90.1
State and local	10.0	33.5	72.3	116.0	143.4	178.6	192.0	208.7
Medicaid[c]	2.4	11.5	24.1	44.8	64.7	85.0	92.2	102.9
Other state and local[d]	7.6	22.0	48.2	71.1	78.7	93.6	99.8	105.8
Average annual growth from prior year shown								
NHE	10.6%[a]	12.9%	10.8%	9.7%	5.3%	6.2%	8.5%	9.3%
Private funds	8.5	12.0	11.3	8.5	4.3	6.7	7.5	9.3
Consumer payments	8.0	12.0	11.1	8.7	4.1	7.1	8.4	9.5
Out-of-pocket payments	6.9	8.8	9.3	4.3	2.5	5.9	4.1	6.0
Private health insurance	10.2	15.9	12.5	11.3	4.8	7.7	10.3	10.9
Other private funds	14.0	11.6	12.8	6.8	6.2	2.9	-0.9	7.2
Public funds	15.4	14.3	10.1	11.5	6.6	5.7	9.7	9.4
Federal	20.1	15.0	10.1	12.2	7.0	4.9	10.7	9.7
Medicare	–[e]	17.2	11.4	10.8	9.0	2.4	9.5	8.4
Medicaid[c]	–[e]	17.7	10.0	19.9	5.4	7.7	11.5	11.8
Other federal[d]	9.6	10.6	7.3	7.7	3.1	9.1	12.8	10.2
State and local	10.2	12.8	10.1	9.9	5.4	7.6	7.5	8.7
Medicaid[c]	–[e]	16.8	9.6	13.3	9.6	9.5	8.4	11.6
Other state and local[d]	7.2	11.2	10.3	8.1	2.6	6.0	6.6	6.0

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
NOTE: Numbers may not add to totals because of rounding.
[a] Average annual growth, 1960–1970.
[b] Average annual growth from prior year shown; represents average growth over several years.
[c] Includes State Children's Health Insurance Program (SCHIP) expansion (Title XIX).
[d] Includes SCHIP (Title XXI).
[e] Not applicable; Medicare and Medicaid became effective in July 1966.

(PPS) for inpatient hospital services, per enrollee costs for these common services in Medicare have actually grown more slowly than in private insurance. Although this is cited as evidence of Medicare's ability to contain cost growth, it is difficult to unravel the effects of growing first-dollar coverage and expanded benefits in private health insurance during the 1990s when Medicare's coverage remained relatively unchanged.[4] In the most recent period (1999–2002) Medicare per enrollee spending grew 6.2 percent for these benefits, compared to with per enrollee growth in private health insurance of 8.7 percent. During this period Medicare spending responded to a series of policy changes aimed at better managing public funds, while private health insurers responded to consumers' demands for more costly, less tightly managed plans. In the Federal Employees Health Benefits Program (FEHBP), often cited as a market-driven model for Medicare reform, per enrollee growth for a common benefit package has been estimated to be similar to that for all private health insurance during 1985–2002.

■ **Medicaid.** Medicaid spending rose 11.7 percent to $250 billion in 2002, compared with 10.2 percent growth in 2001, reflecting

EXHIBIT 5
Annual Per Enrollee Growth In Medicare Spending And In Private Health Insurance And FEHBP Premiums, Calendar Years 1970–2002

	All benefits (%)			Common benefits[a] (%)		
	NHE			NHE		
Calendar year	Medicare	Private health insurance	FEHBP	Medicare	Private health insurance	FEHBP
1970	7.0%	14.8%	11.1%	7.9%	15.7%	12.1%
1971	8.3	13.6	21.6	9.4	10.9	18.7
1972	8.4	15.3	15.0	8.2	11.1	10.8
1973	4.3	9.5	-3.5	3.9	9.6	-3.4
1974	21.3	11.3	15.8	21.1	15.7	20.4
1975	17.9	14.5	12.8	18.6	14.2	12.5
1976	16.9	24.9	31.4	16.7	20.4	26.8
1977	13.0	21.0	7.1	14.4	16.1	2.8
1978	13.5	11.8	11.6	13.0	10.1	9.9
1979	13.0	14.5	3.1	13.5	16.5	4.9
1980	18.3	12.9	–[b]	18.8	15.2	–[b]
1981	17.6	16.5	–[b]	17.5	15.5	–[b]
1982	14.8	14.9	18.7	15.2	13.2	17.0
1983	11.8	10.8	30.6	11.7	8.8	28.3
1984	9.4	13.0	12.7	9.2	8.2	7.9
1985	6.4	9.6	0.6	6.1	10.0	1.0
1986	4.8	1.6	-10.1	5.2	5.0	-7.2
1987	5.9	8.7	18.5	6.1	10.9	20.9
1988	5.2	17.0	25.9	4.4	15.0	23.8
1989	11.5	16.2	25.3	9.3	12.9	21.7
1990	6.9	12.7	9.9	7.2	12.9	10.1
1991	7.6	9.6	5.4	6.3	10.9	6.5
1992	10.5	8.3	8.5	8.9	8.0	8.2
1993	6.7	9.2	8.3	4.7	7.3	6.4
1994	10.2	3.8	2.8	8.1	1.8	0.9
1995	8.3	5.2	-3.7	7.1	3.1	-5.7
1996	6.9	3.7	0.3	5.9	1.9	-1.5
1997	4.6	4.4	2.1	4.9	3.6	1.2
1998	-0.6	4.6	8.0	0.4	4.0	7.3
1999	0.8	5.7	8.1	2.1	3.0	5.4
2000	4.1	7.7	8.7	4.1	7.0	8.1
2001	8.5	10.9	12.3	7.9	9.4	10.7
2002	6.7	11.4	15.1	6.5	9.7	13.4
Average annual growth rate by period (%)						
1969–2002	9.3	11.1	10.6	9.1	10.1	9.6
1969–1985	12.5	14.2	13.2	12.7	13.1	12.1
1985–2002	6.3	8.2	8.2	5.8	7.4	7.3
1985–1991	7.0	10.8	11.7	6.4	11.2	12.1

EXHIBIT 5
Annual Per Enrollee Growth In Medicare Spending And In Private Health Insurance And FEHBP Premiums, Calendar Years 1970–2002 (cont.)

	All benefits (%)			Common benefits[a] (%)		
	NHE			NHE		
Calendar year	Medicare	Private health insurance	FEHBP	Medicare	Private health insurance	FEHBP
1991–1993	8.6	8.7	8.4	6.8	7.6	7.3
1993–1997	7.5	4.3	0.3	6.5	2.6	-1.3
1997–1999	0.1	5.2	8.1	1.3	3.5	6.3
1999–2002	6.4	10.0	12.0	6.2	8.7	10.7

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary; and Office of Personnel Management, Office of the Actuary.

NOTES: Per enrollee includes primary policyholder plus dependents. Federal Employees Health Benefits Program (FEHBP) spending excluding certain benefits was estimated based on the share of total premiums these benefits accounted for in private health insurance overall. NHE is national health expenditures.

[a] Benefits commonly covered by Medicare and private health insurance: hospital services, physician and clinical services, other professional services, and durable medical products.

[b] FEHBP estimates of enrollment and premiums in 1980 did not include low-options plans, causing the estimates of per enrollee premiums to be inconsistent with other years. Therefore, growth rates were not calculated for these years.

growing demands on government programs as the labor market remained weak. The growth during these two years far exceeded recent growth rates, which averaged 6.7 percent during 1995–1999. Slower growth during these years was attributed to a strong economy and consequently slower growth in the number of adults enrolling in Medicaid, and other factors such as increased use of managed care plans. Between 2000 and 2002 the weak labor market along with program expansions helped drive a 5.6 million increase in the number of children and adults eligible for Medicaid.[5] State Children's Health Insurance Program (SCHIP) campaigns contributed to these enrollment gains as outreach programs identified Medicaid-eligible people. Although the growth in adults and children accounted for approximately 85 percent of the growth in the number of eligible people, they accounted for only 36 percent of the increase in Medicaid spending. A small increase in aged and disabled recipients, along with their much higher per recipient spending compared with other enrollees, accounted for most of the increase in Medicaid spending.[6]

Rapidly increasing Medicaid spending combined with states' slow revenue growth has led forty-five states to institute measures aimed at controlling spending growth.[7] These include provider rate freezes or reductions, cuts in discretionary benefits, and specific policies to contain the growth of prescription drug spending. Some states have made plans for higher Medicaid drug copayments or are imposing them for the first time.[8]

In recent years states have looked for fiscal relief. Among the mechanisms used were upper payment limit (UPL) arrangements and disproportionate-share hospital (DSH) payments, which shifted some spending from state to federal governments. Those UPL and DSH funds returned by hospitals and nursing homes to state budgets for other uses are not counted in this paper.[9] New legislation will help lessen the burden of high Medicaid spending growth on states. The Jobs and Growth Tax Relief Act of 2003 raises the federal matching rate for states that maintain their eligibility criteria and thus lowers the percentage of Medicaid costs that states must pay. States that tighten eligibility standards

and thus cut their Medicaid spending would then receive a smaller percentage of federal aid than those that do not, perhaps leading some states to safeguard Medicaid eligibility.[10]

■ **Private insurance.** Private health insurance covers approximately 70 percent of the noninstitutional population, but because it tends to cover a younger and less costly population, it accounts for a much smaller share of overall health care spending (35 percent).[11] Spending for benefits rose 9.6 percent in 2002, with 37 percent of the growth spent on hospital care, 32 percent on physician services, and 26 percent for prescription drugs.

Aggregate private health insurance premiums rose 10.9 percent in 2002, compared to 10.3 percent in 2001, to reach $549.6 billion. Premiums per covered worker rose even more rapidly than aggregate premiums, because premiums calculated in this paper combine changes in the number enrolled—which fell during 2002—with changes in per worker rates. A few key factors have contributed to the rising trend in insurance premium costs, the most notable being the high rate of growth in claims and the rising net cost of insurance (the difference between private health insurance premiums earned and benefits incurred includes administrative costs and profits earned). Net cost totaled $70.2 billion in 2002, or 13 percent of private health insurance premiums, up from 12 percent in 2001.

In the aggregate, enrollment in employer-based coverage declined for the second year in a row. In both 2001 and 2002 enrollment in employer plans declined by about 1 percent, a consequence of lower employment, a shift in employment to smaller firms that offer insurance less frequently, and higher employee-paid costs, which might have reduced take-up rates.[12] Losses in job-based coverage might not be over, as employment declines continued into 2003.

Although employers' spending for health benefits as a share of compensation held steady during the mid-1990s, it has crept upward since 1999. Data for 2003 reveal a health benefit share of compensation comparable to the 1993–1994 period, when rapidly rising health costs prompted employers to evaluate alternatives to conventional coverage more intensely.[13] To counter the rising burden, some employers have shifted expenses to employees through higher premiums, copayments, or coinsurance; some have reduced benefits or dropped coverage altogether.[14]

Consumers are increasingly facing higher copayments and deductibles. In particular, workers are facing increased drug copays and more frequently are given incentives to select less costly drugs under tiered cost-sharing arrangements. More than half of covered workers were enrolled in three-tier plans by 2002, compared with 29 percent in 2000.[15] In 2001 and 2002 more than half of the rise in aggregate out-of-pocket spending was related to increased drug spending, whose share of out-of-pocket spending was higher than that of most other health care services.

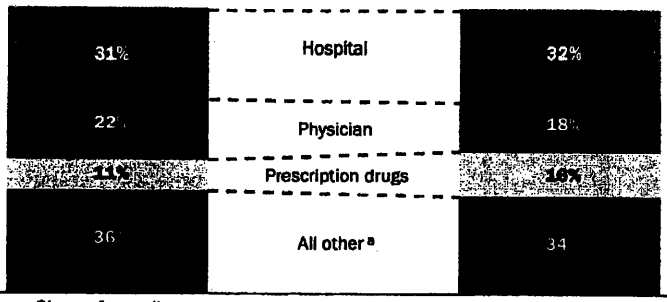
Employers' efforts to shift increases in health care costs to consumers have slowed the relatively steady drop in the out-of-pocket share of spending.[16] While this share declined from 21 percent in 1988 to 15 percent in 1994, it has fallen more slowly since then. In 2002 it was 13.7 percent, as aggregate out-of-pocket spending ($212.5 billion) grew 6.0 percent, its fastest pace since 1998. This faster pace of growth could reflect a rising uninsured population as well as rising copays and deductibles paid by the privately insured.[17]

Spending By Service

Growth in spending accelerated for most services. Retail prescription drug sales continued to grow at the fastest pace. Increases in the spending rate for the largest spending category—hospitals—caused its share of the spending increase in 2002 to exceed its share of total health spending for the first time since 1991 (Exhibit 6).

■ **Hospitals.** Hospital spending ($486.5 billion) rose 9.5 percent in 2002, the fourth year of accelerated growth following a period of managed care expansions during 1993–1998 when hospital spending growth averaged 3.4 percent. Medicare spending rose 8.8 percent in 2002, contributing 29 percent of the increase.

EXHIBIT 6
Providers' Shares Of Health Spending And Of The Increase In Health Spending, 2002



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
[a] Includes spending for dental, other professional, and other personal health care services; home health and nursing home care; durable and other nondurable medical products; administration and insurance net cost; government public health; medical research; and medical construction.

The trend in 2002 reflects growing demand for services, rising compensation and other expenses, and hospitals' increasing ability to negotiate higher prices from private payers.[18]

Growth in hospital spending can be disaggregated into population, price, and a residual component that primarily includes changes in quantity and intensity of services consumed.[19] In both 2001 and 2002, increases in prices played a dominant role in the escalation of hospital spending, although acceleration in the residual also occurred. Of the 7.5 percent and 9.5 percent increases in hospital spending in 2001 and 2002, price factors were responsible for 3.6 percent and 5.0 percent of the growth. Growth in quantity and intensity factors of 3.0 percent and 3.6 percent in 2001 and 2002, more rapid than in earlier years, also contributed to faster spending in the hospital sector, but to a lesser degree. Population growth accounted for the remaining 0.9 percent growth in each year.

A large share of hospital-specific price inflation could be tied to payroll and other input costs. In the hospital sector, compensation is estimated to account for 62 percent of operating expenses.[20] Growth in compensation costs per hour worked for civilian hospital employees grew rapidly in 2001 and 2002 at 6.4 percent and 6.4 percent, respectively, compared with average annual compensation growth of 2.7 percent during 1994–2000.[21] Rising wages associated with the nursing shortage, benefit cost increases, and rising malpractice costs absorbed by hospitals in certain areas have contributed to larger increases in hospital prices over the past few years.[22] Additionally, hospitals have regained market power since the mid-1990s, improving their negotiating power and ability to secure rate increases from private insurance plans.

Some of the recent growth in hospital spending reflects increases in hospital volume, as measured through admissions and average length-of-stay. Hospital inpatient days declined 23 percent during 1990–2000, mostly through reductions in length-of-stay. Following this decline, inpatient days rose 1 percent in 2001 because of stabilization in days per stay as admissions continued to increase.[23] More recent indications of growing demand for hospital services come through hospital employment, which grew 2.5 percent in 2002 compared with an average of 0.6 percent in 1994–2001. Through July 2003, however, growth in employment moderated, perhaps signaling slower growth in utilization.[24]

■ **Physicians.** Spending growth for physician services rose by 7.7 percent in 2002, decelerating slightly from 8.6 percent growth in 2001 and reaching $339.5 billion. While Medi-

EXHIBIT 7
Expenditures For Health Services And Supplies, By Type Of Service And Source Of Funds, Calendar Year 2002

		Private funds			Public funds			
Spending category	Total	Total[a]	Out-of-pocket	Private health insurance	Total	Medicare	Federal and state Medicaid[b]	Other public
Health services and supplies (billions)	$1,496.3	$819.7	$212.5	$549.6	$676.6	$267.1	$250.4	$159.1
Personal health care	1,340.2	748.1	212.5	479.3	592.2	259.1	233.7	99.4
Hospital care	486.5	200.1	14.7	165.0	286.4	149.2	83.5	53.7
Professional services	501.5	328.4	78.2	218.9	173.2	75.4	62.2	35.6
Physician and clinical services	339.5	224.7	34.3	166.9	114.8	68.8	24.7	21.3
Other professional services	45.9	33.2	13.0	17.2	12.6	6.4	2.4	3.8
Dental services	70.3	65.8	30.9	34.8	4.5	0.1	3.8	0.7
Other personal health care	45.8	4.7	–[c]	–[c]	41.2	–[c]	31.2	9.9
Nursing home and home health	139.3	51.4	32.4	14.4	87.9	24.3	59.3	4.2
Home health care[d]	36.1	14.3	6.5	6.7	21.9	11.4	8.4	2.0
Nursing home care[d]	103.2	37.1	25.9	7.7	66.1	12.9	50.9	2.2
Retail outlet sales of medical products	212.9	168.2	87.2	81.0	44.7	10.2	28.6	5.9
Prescription drugs	162.4	126.2	48.6	77.6	36.2	2.6	28.6	5.0
Durable medical equipment	18.8	11.9	8.5	3.5	6.8	5.9	0.0	0.9
Other nondurable medical products	31.7	30.1	30.1	–[c]	1.6	1.6	–[c]	–[c]
Program administration and net cost of private health insurance	105.0	71.7	–[c]	70.2	33.3	8.0	16.8	8.5
Government public health activities	51.2	–[c]	–[c]	–[c]	51.2	–[c]	–[c]	51.2

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

NOTE: 0.0 denotes amounts less than $50 million. Numbers may not add to totals because of rounding.

[a] Includes other private funds.

[b] Includes Medicaid State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

[c] Not applicable.

[d] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

care accounted for only 20 percent of payments to physicians ($68.8 billion), it was the primary driver behind decelerating spending in 2002 (Exhibit 7). Under the Medicare payment formula that was recently revised by the BBA, weak economic growth coupled with rapid growth of previous years' spending for physician services caused the factor used to update physician fee schedule payments to decline by 4.8 percent.[25] Despite the large payment reduction, Medicare physician spending grew by 5.8 percent, a 3.8-percentage-point deceleration from Medicare's 2001 spending growth of 9.6 percent, because of sizable growth in the volume and intensity of services delivered. On a per enrollee basis, Medicare spending for physician services grew 5.6 percent between 1990 and 2002, slightly slower than growth in per enrollee private health insurance spending (7.4 percent).

■ **Drugs.** Spending for prescription drugs decelerated slightly for the second year in a row, increasing 15.3 percent in 2002 following growth of 15.9 percent in 2001 and 16.4 percent in 2000. Growth in Medicaid drug spending, excluding SCHIP expansion programs, decelerated nearly four percentage points in 2002. This spending growth was dampened as states

made greater use of preferred drug lists in conjunction with prior-authorization policies for selected drugs, increased copayments, or required the use of generic drugs before allowing more expensive therapies.[26]

Other factors that could have contributed to slowing aggregate growth included fewer new drugs entering the market (only seventeen in 2002, compared with an average of twenty-five per year in the 2000–2001 period and thirty-five in 1999); a shift in prescriptions toward more generic drugs; continued growth of tiered copayment plans; and a slight decline in direct-to-consumer (DTC) advertising.[27] These factors were somewhat offset by continued growth in demand.[28]

While private spending for prescription drugs grew at nearly the same rate in 2002 (15.4 percent) as in 2001 (15.2 percent), out-of-pocket spending rose more rapidly and private health insurance spending less rapidly than in 2001. Out-of-pocket spending for prescription drugs accelerated by 3.5 percentage points to 14.4 percent in 2002, while private health insurance spending slowed by 2.1 percentage points to 16.1 percent. Faster growth in out-of-pocket spending and slower growth in private health insurance likely reflect changes in coverage among Medicare+Choice and employer-sponsored plans as well as the moderating impact that increasing copays have on prescription drug consumption.

■ **Home health.** Spending for freestanding home health agency services grew by 7.2 percent in 2002, the second consecutive year of expansion, driven mostly by Medicare. Industry growth is beginning to stabilize following a period of changes to Medicare policies. These policies led to a substantial $4.6 billion drop in Medicare spending between 1997 and 1999 that has been partially offset by an increase of $2.9 billion in Medicare spending since then. This rebound in Medicare, the largest single payer for home health services, has been driven by the implementation of the PPS in October 2000. Medicare spending for home health services grew only 0.6 percent in 2000, compared with 17.6 percent in 2001 and 13.3 percent in 2002. Recent rapid growth in Medicare is partly a result of a change in the interpretation of "homebound" that expanded the number of beneficiaries eligible for services. Countering double-digit growth in Medicare spending, slowing Medicaid spending contributed to the seven-percentage-point deceleration in overall public funding for home health in 2002.[29]

While public spending growth for home health agencies decelerated rapidly in 2002, the downward trend in private spending appears to be subsiding. Private spending grew by 1.0 percent in 2002 in comparison to a decline of 7.4 percent in 2001. To some extent, the industry's labor crisis has contributed to the loss of private customers in recent years. Private payers might be seeking alternative care through assisted living facilities or private-duty nurses. In 2002 the weakening economy aided home health agencies' capacity to deliver services as the availability of aides grew, allowing agencies to fill more vacancies.

■ **Nursing homes.** Spending for services provided by freestanding skilled nursing care facilities continued at a moderate growth rate of 4.1 percent, slightly slower than the 5.7 percent rate in 2001. This correlates with slow growth in nursing facility capacity and a deceleration in the costs of supplies and services used in the provision of care.[30] Despite a deceleration of 0.8 percentage points in public spending for nursing homes in 2002, the public share of payments rose to 64 percent of overall payments, with Medicaid paying 49 percent. States also are seeking to shift more patients from nursing homes and other institutions to community-based settings as they comply with the *Olmstead* interpretation of the Americans with Disabilities Act that encourages the treatment of people with disabilities in less restrictive community settings.[31]

Summary And Concluding Comments

The continued acceleration in health care spending growth has posed financial challenges for government, businesses, and individuals alike. Compared with economic growth of 3.6 percent, growth in health spending of 9.3 percent pressures employers to cut

other spending increases, possibly through reducing jobs, wage gains, or health benefits or through shifting more costs to employees. State and federal governments face the same dilemma of costs rising more rapidly than revenues, leading every state to scrutinize discretionary Medicaid benefits as the number eligible for coverage continues to grow.[12]

Forty-four percent of spending growth was attributed to economywide and medical-specific inflation as the personal health care deflator rose 3.9 percent in 2002, compared with 8.8 percent growth in personal health care spending. Recent health care price inflation is affected by a shortage of health care workers, which is expected to continue to propel higher-than-average increases in payroll costs. Hospitals' improved negotiating power has also led to higher rate increases from private insurance plans.

Factors fueling growth in health spending are already showing signs of dissipating in 2003. Preliminary data indicate that hospital use has eased and that wage growth in the health sector has decelerated slightly. Furthermore, Medicare givebacks have expired, and states have begun plans to curtail Medicaid spending growth. Finally, as consumers share more of the increases in cost, the value of health services will be more closely weighed against other purchases, underscoring the considerable value of some services and the discretionary nature of others.

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NOTES

1. "Other private funding" includes privately funded construction for health facilities, industrial in-plant services, and nonpatient revenues including philanthropy.
2. Bureau of Labor Statistics, Current Employment Statistics (sum of federal, state, local, and private hospital employment), www.bls.gov/ces/home.htm (12 August 2003).
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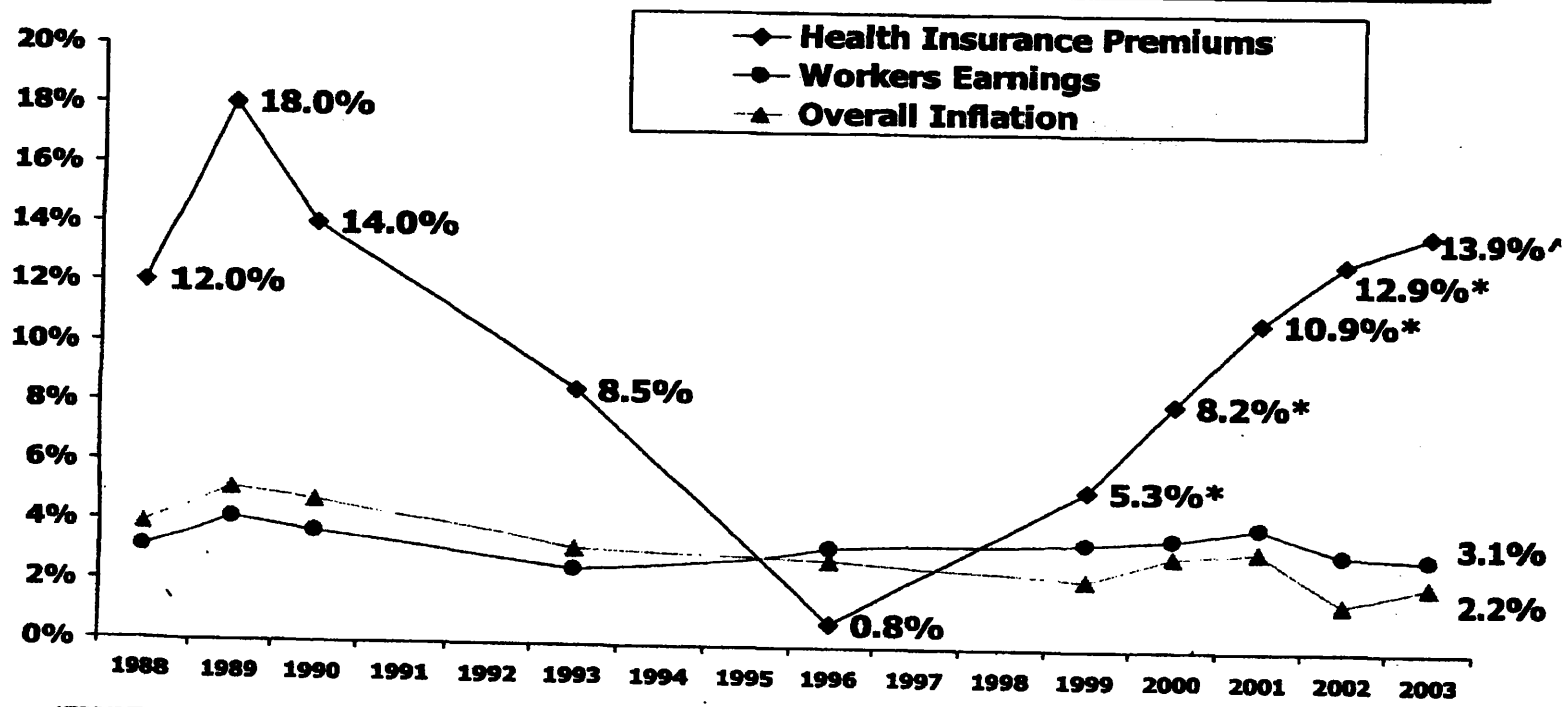
D

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits:1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2003; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2003.

*Estimate is statistically different from the previous year shown at $p<0.05$: 1996-1999, 1999-2000, 2000-2001, 2001-2002.

^ Estimate is statistically different from the previous year shown at $p<0.1$: 2002-2003.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

E

It happened -- well, let me explain what is happening now. That stopped around the end of the decade.

Q 2000?

A Around 2000.

And since 2000, both health care spending has been growing in a robust way and, at least until this past three quarters, the economy, not. And that has had two impacts.

The first is the absolute level of health care spending has now been rising at 8, 9 percent per year, a very substantial growth, and the economy, until the third quarter of 2003, had been dragging along, which means that health care spending, which had been running about 13 percent of GDP for almost the entire decade of the 1990s, last year jumped to just under 15 percent, about 14.9 percent.

It appears that there's been a small moderation in health care spending, not a lot, and it appears that the GDP has been growing more rapidly the third, fourth quarter of last year and the first quarter of this year.

So presumably, 2003 won't look quite as bad as 2002, but we are not anywhere near that

period of stability that we experienced in the 1990s.

Q Has the growth in health care spending been in excess of the unit rate increases for physicians, if any?

A The growth in spending in health care has run in general two to three times the economy, and physician spending has not been one of the primary drivers of health care spending growth.

Right now, it is -- hospital spending has been the single largest factor. Earlier in this decade it was in part pharmaceutical spending, which was growing rapidly, 17 or 18 percent, but pharmaceutical spending is not quite 10 percent of the health care dollar, so although it has received a lot of attention, it actually doesn't contribute quite as much to health care spending as people might think.

Q If hospitalization has been growing at a very rapid rate, how much importance is it to have physicians who, in fact, are alerted to that and are concerned about that?

A People don't get admitted to hospitals without a physician being a participant and making sure that appropriate use of hospitals is

obviously a way to try to modify both hospital expenditures as well as pharmaceutical expenditures since, again, individuals don't receive prescriptions without having a physician write them.

I don't want to make this sound like, you know, this is some silver bullet to making all things well in the United States, but they are an active component to trying to moderate health care spending because they are actively involved in the care of individuals.

Q Do you believe that a solution has yet been found to the health care increases that you've been talking about, the health care cost increases?

A Well, there are a variety of ways that countries have adopted to try to moderate spending, most of which would be politically unacceptable in the United States.

What we tried in the 1990s, which did moderate spending substantially but which has turned out to be not very popular with the public, is a combination of aggressive purchasing by employers and plans, health care plans, and aggressive use of managed care, trying to limit

F

network or likely activate some portion of the network?

A My understanding, based on conversations that I've had primarily with Dr. Van Wagner, is that on an annual basis, physicians are asked what would be a minimum fee that would be acceptable to them. I don't know how high the response rate is to that poll, but that information comes in and its answers -- the poll is kept to the management of NTSP, and the answers are used to try to assess whether or not this will meet the median or -- or mean amount of fee that the physicians have said they will regard as a minimum.

JUDGE CHAPPELL: You need to speak up, ma'am.

THE WITNESS: Okay.

BY MR. HUFFMAN:

Q Have you reached an opinion as to whether the NTSP business model would be effective and beneficial to health care?

A I believe that risk-taking models of delivery encourage efficiency and drive the providers, in this case the physicians, to work together in a way that is helpful for quality as

well as efficiency and therefore, I look at NTSP as one of the relatively few physician groups that are not only interested in taking risk, but are actively seeking new risk contracts.

We are going through a period of transition in this country where we have moved away from what had been an active managed care environment in the 1990s to something else, but it's not clear yet what that something else is. Risk behavior that characterizes the NTSP business model is something that is very helpful in terms of getting efficiently delivered health services.

I don't know how much a part it will be of -- of the future because it has been a declining model in general in the United States, and as I understand it, NTSP is the only specialty physician organization in this part of Texas that continues to take risk.

Q Do you believe that the portion of the NTSP business model to achieve spillover into fee-for-service contracts will be beneficial to health care?

A I do.

Q Can you explain why?

A What we know about spillover is the

following: There have been empirical studies that look at what happens as a community has increasing amounts of groups that take risk, financial risk, and it appears that as the number gets bigger, the revenues are larger, that it's not only the patients that are part of the risk groups that are affected, but spending in the community as a whole is affected in a favorable way.

JUDGE CHAPPELL: Have you determined whether or not there's any spillover in this case as we sit here today?

THE WITNESS: It appears that there is similar results when you look at spending patterns between the risk groups and the nonrisk groups that NTSP covers.

JUDGE CHAPPELL: Go ahead.

MR. HUFFMAN: Thank you.

BY MR. HUFFMAN:

Q We were talking about the spillover model and I think you were explaining how it works, why it's beneficial. Can you continue, please?

A The reason it is important to think about what might be causing the spillover effects is some parts of that behavior change are more

easily transferred to a fee-for-service system than other parts or to imagine what might happen. Most of the empirical research has been at an aggregative level in response to the judge's inquiry, looking at what happens to overall spending in the area with assumptions about why spending is moderated in the presence of a lot of risk group behavior.

In the case of NTSP, there are certain activities that they engage in, certain triggers that they use to follow on patients who may have had an adverse event happen, who are ordering oxygen, indicating they may have congestive heart failure and therefore be candidates for disease management.

They follow certain routines to make sure they're screening for Pap smears and mammography for women.

Many of these activities, once put in place as part of a physician's behavior, are likely to be continued in a nonrisk environment. The problem has been getting them in practice.

There may be some activities, although I'm not aware of them in NTSP, that if a physician had a choice outside of a risk program that was

imposed on him by a plan that they wouldn't use. So if you are practicing in -- in Medicaid, and -- there may be certain rules that you have to place.

What I have observed in the NTSP programs are a series of medical management strategies that appear to improve quality and to provide efficient care, and I have read letters that NTSP has sent to other payors trying to interest them in availing themselves of the medical management that it engages in in their fee-for-service world, so I believe the kinds of activities that they are doing that can be transferred or are cost effectively transferred will be transferred.

There may be some parts that won't be transferred because the supporting information would not be available in a fee-for-service system or it may be too costly if there is no specific payment for medical management in the fee-for-service. But some of the medical management strategies are very low cost, are issues that all payors are trying to get put in place and, once in practice, I believe will be adopted.

I have attempted to find out whether

there has been specific empirical studies done on the issue of what happens to physicians who practice in both a risk environment and a nonrisk environment. I have contacted people running plans, I have contacted many of the researchers actively involved in this area.

I am as sure as I can be that this research has not specifically been done, so I can say I believe it is supported by the empirical evidence that is available and -- but -- what I have seen written, but I will acknowledge that as best I can tell, it has not been specifically researched.

Q If a physician learns a good lesson in risk treatment, for example, who's the best facility to send something to, how long a patient goes there, etc., what does the literature tell us about -- I'm sorry, what does logic tell us that physician will do when presented with an opportunity to use that same lesson in nonrisk contracts?

A There is actually some information, not specifically risk to nonrisk, but what happens as you educate physicians on adopting good quality behavior and whether or not they will continue

doing that when they leave the specific event where it occurred.

And the answer is they will, but there's a high recidivism rate, so it means frequent reinforcement.

Many of the issues that this country is struggling with now in terms of trying to improve quality care involve low-cost technologies or procedures using aspirin or beta blockers following a heart attack, doing eye screens or foot exams for diabetics, having Pap smears for women, PSA tests for men, digital rectal exams for people over 50.

These are not doing eye tests for glaucoma, these are not expensive interventions. Insurance for the most part will pay for it. But frequently, it doesn't happen, and part of what medical management can do in these simple cases, as an example, is to get physicians routinely used to following these procedures.

It's very hard to imagine that they wouldn't follow them as they move in a nonrisk environment.

Some of the other strategies may be more complicated or may be more costly and may or

may not transfer, depending on whether or not you have the information to identify what the problem is or to impose a -- a solution.

Disease management is a -- is an example. Congestive heart failure is very expensive, particularly if people get out of control, but it's been shown that if people follow their meds and make sure that they are kept in a stable position, you can lower emergency room use. And this is the kind of a disease management program that NTSP refers its risk people to and that Core Solutions, the company that I'm a director of, makes use of and sells or is involved with in providing for both public and private companies that wish to use this service.

So some of the services might not be so readily transferrable, but some of them will be.

Q What is the advantage to having the same group involved in risk contracts and also nonrisk or fee-for-service contracts?

A Well, there is some literature, although this is more based on what I have been told. It's not really economic literature that suggests that peer review is an important

phenomenon in how you provide both high-quality and cost-effective medical care.

I have spent some time at the Mayo Clinic and have spoken with the past and current director of the Mayo Clinic, and they believe that it is an important factor in why a place like the Mayo Clinic is able to not only have very high quality but actually delivered at quite a -- a low cost.

In addition to that type of peer review, though, there are referral patterns and referral facility use that is likely to occur and if satisfactory and of high quality and of reasonable cost, is also likely to be transferred unless not permitted in the fee-for-service environment, which may be the case. It may be that the other payor has its own relationships with facilities and that would not permit all of the referral that would otherwise occur.

Q Is there any advantage to having doctors engaged continuously in a risk contract as far as achieving or promoting spillover?

A I believe that there is advantage in having as much involvement as you can to try to ingrain the kinds of behaviors that are going on

in medical management than in the risk group as part of the risk group's activity to both protect itself financially and to provide good quality care.

There is interest now being expressed by Medicare, for example, to see whether it will be possible to pay for medical management to be provided in a fee-for-service setting, since it appears that fee-for-service is going to remain, at least in the short term, the dominant form of health care in both the private and the public sectors, and therefore, there is a lot of interest in trying to figure out whether it is possible to adopt some of what is going on in risk-based groups that are believed to be beneficial to a nonrisk environment.

It's also why I have been impressed that NTSP appears to be seeking additional risk contracts when it can and even using its nonrisk fee-for-service basis as a lure almost, as a -- a come let us show what we can do, we'd really like to have you become part of our risk program.

I'm very pleased to see it. It's very unusual in today's environment.

Q If NTSP is using fee-for-service

contracts as sort of a lure to try to persuade payors or employers to go to a risk model, would NTSP be able to have success if on the fee-for-service side it was involved with lower quality doctors than are normally involved on its risk panel?

A Presumably, if there are doctors it would not want in its environment for whatever reasons then it would feel it couldn't produce the product and service it produces in its risk panel.

Q If NTSP were forced to be involved in contracts that involve lower quality doctors, would that adversely affect NTSP's reputation and specifically NTS reputation as a risk provider?

A Well, it depends on -- the answer is yes, and it depends also on what precisely the grounds were that they didn't want to be involved with the doctors in their risk plan.

It may be that their procedures are of adequate quality but they're very aggressive in what they do without any improved clinical outcomes, which would also make them a group that might damage their reputation as being an efficient provider of health care.

It is both doing what you need to do,

doing it well and not doing very much of what you don't need to do.

Q If NTSP had developed teamwork routines and handoffs on the risk side, would it be able to perform as well on the fee-for-service side if it had to involve new doctors or lesser quality doctors?

A I presume there would not be the relations there that there had been with their own panel.

Q In developing teamwork in a multispecialty situation, is it important for the handoffs to be worked out between the PCPs to the specialists to the facilities, etc.?

A It is important. It, of course, occurs in nonrisk environments. The question is whether some of the strategies to involve medical management, not just for utilization but to improve quality, are as likely to occur with a new group. The fact is most health care is provided in nonrisk environments and so, of course, handoffs do occur, but to the extent that you have medical management strategies such as the ones that I mentioned that this group is used to doing involving other primary care or specialty

you can have a similar quantity, but if you start using more and more expensive therapeutics or interventions, days in the hospital may become much more expensive or you may have no increase in the days in the hospital but they may become much more expensive because of what happens in the five days that you do have in the hospital.

That has been much more the driver of health care spending in the US.

Q How important, in your opinion, is it to have physicians who are motivated and concerned about utilization and also the costs that are going on in facility and pharmacy?

A In my opinion, it is very important to have physicians motivated and involved. Part of what happened toward the end of the 1990s and what has been referred to as an antimanaged care backlash, when a lot of push-back went to the managed care companies who had been successfully moderating spending in the 1990s, was resentment by patients at not being able to see their physicians or their specialists or get access to new technology and resentment by physicians that they were being looked to to provide many of the savings but no one thought they should have any

motivation or financial gain in producing any of these savings.

Because so much of what goes on in health care is a reflection of a physician directive prescribing medicines, prescribing therapies, it is extremely important to have the physician involved and motivated to make the change.

And in both heading these commissions that I did, in speaking to physician groups, which I do, not on a regular basis but quite frequently, I have again and again heard complaints that hospitals expect physicians to produce major savings, that health plans and health payors expect physicians to produce major savings, but no one seems to think that they should receive monies for medical management or providing the services that might help to produce these savings.

Q How does a capitation contract motivate and orient physicians to controlling utilization and understanding the cost savings potentials in facility and pharmacy?

A Well, the -- I guess the colloquial expression would be they now have skin in the game.

There is a fixed amount of money that will be available to take care of the physician services that will be required by a given population and it is a motivator to make sure you do what you need to both for clinical outcomes and for patient satisfactions, both of which will be monitored, but to be careful to not do things with low payoffs because that will hurt you as a group and also in the eyes of your compatriots.

Q How does spillover from a capitation contract offer potential benefits in fee-for-service contracts?

A It again goes to the kinds of activities that are engaged in as part of medical management. The ones that prompt physicians to do what all of them would regard as good medical behavior, they just may forget to do it -- or not have been concentrating on it that are low cost and that have -- that will require no more information than they would normally have from a patient, presumably will be done unless you believe physicians would deliberately try to withhold good care, which I do not believe.

I think it is a question of getting them into the pattern of following good practice

behavior in areas which for whatever reason has not been happening and which has been driven in a capitated environment.

Q Does having the physicians have skin in the game in a capitation model tend to have an impact on their self-selection of the physicians who will be involved on the risk side?

A It has been observed by a number of researchers, Jack Winberg is probably the best known, that some physicians appear to have very aggressive practice styles in terms of how they approach their patients and that this aggressive practice style does not appear to be related to either the illness of the patient or even to the facilities available. It -- it's something internal to the physician's training.

If you were in a capitated world, you would either encourage such a physician to look at the outcomes that he or she is having and to review what is being done or you would want to have this person not be a part of your group.

It is -- encourages the sense that you are at risk for inappropriate behavior, especially financially costly inappropriate behavior by your peers.

When I was at Medicare, we put in place a bundled payment model for bypass surgery. This was something very common in the private sector in the 1980s. Texas Heart Institute was one of the most famous places, where you would have a payment that covered all of the services, including all the different physicians you might see in your bypass procedure, and it was pretty low cost and regarded as very high quality.

Medicare was paying for each of the physicians that would be involved in a bypass operation separately and also the facility fee. And as a demonstration, we involved ten centers that came in among 70 or a hundred that requested to be considered to receive a bundled payment covering all of their services to see whether we could have it be more cost-effective, to see what would happen with quality and to see what would happen with patient satisfaction.

I wanted to do it because I believed it would lower some of the unimportant referrals that we kept hearing were going on as physicians might either routinely invite the internists to come back for another visit or the cardiologist to stop in.

But the cardiology advisors from NIH told me he wanted to see the demonstration go on because he believed it would drive the physicians to act together as a team in a way that does not happen in the a la carte fee-for-service world that existed in Medicare for bypass operations.

The demonstration was quite successful, but unfortunately, as usually happens with demonstrations, it has not made its way into law.

Q If the physicians have skin in the game and are in a risk contract, will that have an effect on them when physicians apply to come into the organization as far as the criteria they use for those kinds of applicants?

A I don't know that. I know how well physicians correctly assess their own behavior. Some physicians might know they don't want to be a part of a risk-bearing contract. In fact, I gather that with the new requirement NTSP has adopted, some 75 or 80 physicians have chosen to dissociate themselves, so I guess some people may know either that their style doesn't match this kind of environment or they just don't want to take a chance.

presume. That's why they behaved in this -- and obviously, it takes a personality willing to be part of a group to enter into a group practice and to voluntarily delegate some of their clinical autonomy or financial decision-making to the group.

Q How important is it in a multispecialty context for doctors to have teamwork?

A You want the group to make the best use of providing all of the services within the group. They need to appreciate and understand and engage in teamwork.

Q How important is it to have a multi-specialty group that is trying to engender teamwork in physicians?

A You clearly can accomplish integrated health care in a multispecialty group that is harder to accomplish in a single specialty group. It may not be impossible. We have -- we're becoming a virtual world in many ways, and it is certainly possible to have some of the attributes of multispecialty practice if you had good enough information systems, etc., but it is helpful to be part of a group in some way if you can in terms of

bringing you together, by having more frequent contact.

As I say, it can occur among good physicians, even if they're not related, but it's easier to have it not happen if you're not related in some way.

Q You indicated that NTSP is the only multispecialty IPA entity still left in the north Texas area doing risk contracts. What conclusions do you draw from that?

A Doesn't seem to be a very popular organizational structure for most physicians in this area or they would try to replicate the model.

Q Does that allow you to draw any conclusions as to the ability of NTSP compared to other organizations in north Texas to do the teamwork and other things that are necessary to be successful?

A Well, there -- there is an alternative to having physicians do the medical management, and that is to have the payor do the medical management, but usually, physicians like that even less.

If somebody's going to do something to

practice there have been?

A I think it would be a combination of the -- the direct personnel involved in NTSP. With regard to the medical questions, it should either be the medical director, Peter McDougal, or the specific representatives from each of the specialties who might be involved or Dr. Karen Van Wagner as the executive director. They are the people more intimately involved with issues of practice both in the risk and nonrisk program.

Q Would that include Dr. Tom Deas, the medical director?

A Yes, of course. I forgot his name, yes.

Q Is there anything that was asked of you on cross-examination that has changed your opinion concerning NTSP?

A No.

Q Do you feel that the NTSP business model is one that should be encouraged?

A I do because, as I indicated, we are in a period where fewer entities, especially physician groups, but fewer entities in general are willing to take risk. I believe that groups that are willing to take risk force themselves for

their own financial protection to engage in activities that both produce lower cost care and with patient satisfaction being measured, look at outcomes as well.

The fact that this group is seeking to encourage some of its fee-for-service to become part of a -- a risk group flies in the face of what is generally going on. And though I have not seen the specific protocols with regard to how to treat patients in a fee-for-service nonrisk environment, some of the strategies that are triggered promote better care, add very little additional cost, and I would have to envision a level in physician that would not transfer that kind of behavior to all the rest of the practice, whether it was NTSP-related or not.

And -- and furthermore, the empirical measures that I have seen looking at what happens to patients in the nonrisk environment versus the risk environment suggests that there must be some transference of behavior going on, so it is suggestive and anecdotal but it is clearly in the direction that I would expect it to occur.

MR. HUFFMAN: Your Honor, no further questions.

G

Exhibit G

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H

Exhibit H

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example of applying the normal tools of the trade.

Q Approximately how many hours have you and your staff worked on this matter?

A I -- I don't have a good feel for it. It would be several hundred hours for me, 2- to 300 hours, I'm guessing, for me, and for the staff, an equal amount spread across a number of people.

Q Have you been able to reach conclusions concerning this matter?

A Yes.

Q Can you list those for us, if you can, in general terms?

A My general conclusion is that as I look at the facts and the evidence in this case, that NTSP does not possess market power in any likely relevant market; that -- that the -- the behavior that the FTC complains about in this case is unlikely to lessen competition, given that fact and some other facts in the record; and that -- that the -- the FTC's general view of the messenger model is somewhat flawed in that it -- it doesn't recognize a number of economic facts with regard to incentives; and -- and just the behavior of both payors and IPAs and physicians

within the messenger model.

And then I looked at the efficiencies in this matter, and I think there are reasons to believe that -- that what NTSP learns in its risk contracting accrues to the benefit of payors even in the nonrisk setting.

Q Now, what I'd like to do is turn and -- and talk with you about the detailed opinions that you have in each area. Would starting with market and -- and market power be a good place to start?

A Sure.

Q Can you tell us specifically how you went about -- first of all, let me strike that question.

Did Complaint counsel expert posit any relevant market in this case?

A No, he did not.

Q Given that fact, what did you do concerning your analysis of whether or not there could ever be any market power?

A I -- I didn't attempt to define precisely what the boundaries of the market would be. What I wanted to look at is, given several alternatives and I think in various cases

Q Was some of that data covered by Dr. Van Wagner in her examination?

A Yes.

Q Now, did you perform an analysis to determine whether or not the good practices that NTSP had concerning its risk contracts were being transferred over to the nonrisk treatment?

A Yes.

Q What did you do?

A There were a number of elements to that. One is, to go through the process, we looked at what happened in the PacifiCare case and compared that to what happened in -- in other payment settings. The other payment setting that we had data for was the CIGNA payment setting which, as we said, is the case where PCP doctors are capitated but the -- but the specialists are on a fee-for-service basis plus a bonus arrangement.

And we found in those cases that with regard to the CIGNA population that the results looked very much like the results looked for the PacifiCare population. In other words, the NTSP doctors appear to be performing as well on the CIGNA patients as they were -- under a different

payment setting as they were performing for the PacifiCare patients. Did I say that right? Did I say CIGNA and PacifiCare right?

Q I think you did.

A Okay.

MR. HUFFMAN: May I show the witness RX3130?

JUDGE CHAPPELL: Go ahead.

BY MR. HUFFMAN:

Q Can you tell us what RX3130 is, please?

A This is the data that summarizes the description that I just gave you. We looked at total medical per-member, per-month expenses in the PacifiCare data relative to NTSP's CIGNA data, then we did the same thing for pharmacy, and then the total is just the sum of those two.

So what you see, as Dr. Van Wagner discussed I guess yesterday, was that PacifiCare and CIGNA in terms of medical expenses looked virtually identical, so NTSP physicians appear to be performing no differently with regard to their CIGNA population as they appear to be performing with regard to their PacifiCare population.

Q Now, how does spillover work?

A What the literature says, what the testimony in this case says is, look, I learned to practice a certain way, and -- and yes, I may learn to practice that certain way from the risk contracts that I perform in where I have strong incentives to practice in a cost-effective way but, having learned how to practice in a cost-effective way, I take those practice patterns, referral patterns, what I learn about low-cost providers of laboratories or -- or laboratory services or x-ray services, all the things that I learn from these high-powered incentives I've given in my risk contract, apply -- I apply what I learn in this setting to other contractual settings.

Q Did you review the doctor depositions to see what they had to say about spillover?

A They -- yeah, they -- I included what they had to say in my previous answer, that their testimony is, look, I learned to practice a certain way and, having practiced a certain way, having learned to practice a certain way, I practice the same way in these other settings as well.

Q Did you actually perform some data

analyses concerning some specialties?

A Yes.

Q Can you tell us about those, please?

A We had gotten some data from certain groups that participate in NTSP, and one was a neurosurgery group and another one was an ophthalmology group, and we compared their performance for that group within the NTSP population relative to their performance as they reported in their other contractual settings, which includes -- I don't remember if any of them include the CIGNA data but it includes a whole array of payors in most cases, Blue Cross, Aetna, United, all the contracts or at least all the ones for which these groups could assemble data that they participate in.

Q What did you find from that data?

A Well, what you see generally in the data is that their performance is pretty uniform across the various contracts that they participate in.

Q Now, what conclusions did you draw about whether or not maintaining the same team in risk or, over to nonrisk, whether or not that was needed?

J

use of a utilization management database versus the use of organized processes?

A. Well, I mean, I'm including the use of that database as an organized process, so I assume by "organized processes" you mean organized processes that are directed specifically at improving quality as opposed to managing costs.

Q. Well, actually I was looking at managing costs in that question. Let me clarify it.

A. Okay. So I'm sorry. Ask it again then.

Q. Do you know of any studies that have looked at the positive impact of utilization management in controlling cost versus whatever impact organized processes would have on controlling cost?

A. Other forms of organized processes than utilization management.

No, I'm not aware of such a study.

Q. And isn't it correct that you acknowledge that utilization management can have positive impact on quality?

A. I believe that it can.

Q. I think you stated several ways and one of the ways I believe you stated was that the use of a utilization management database like NTSP has can avoid or prevent or limit overutilization; is that correct?

K

[PUBLIC RECORD]

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

IN THE MATTER OF NORTH TEXAS SPECIALTY PHYSICIANS, A CORPORATION.	**Docket No. 9312**

DECLARATION OF KAREN VAN WAGNER, Ph.D

STATE OF TEXAS §
§
COUNTY OF TARRANT §

I, Karen Van Wagner, Ph.D, do hereby declare and state as follows:

1. I am over the age of eighteen (18) years, am of sound mind, have never been convicted of a felony or a crime involving moral turpitude, and am in all other ways fully competent to make this declaration. I have personal knowledge of the facts set out herein and they are true and correct.

2. I am the Executive Director of North Texas Specialty Physicians ("NTSP"). I have held this position since 1997. As Executive Director, I am familiar with the general business operations and contracting practices of NTSP, as well as the relationship between NTSP and its participating physicians.

3. NTSP currently has 550 participating physicians.

4. NTSP is currently a party to 13 non-risk contracts that are made available through NTSP to its participating physicians. These contracts could affect more than 200,000 patient lives. If NTSP is required to terminate these non-risk contracts, that will also terminate each participating physician from the contracts. This termination will disrupt the physicians' provision of medical

services and financial status as well as potentially disrupting health plans and patient care. Further, termination of these contracts will disrupt the spillover effects NTSP has achieved.

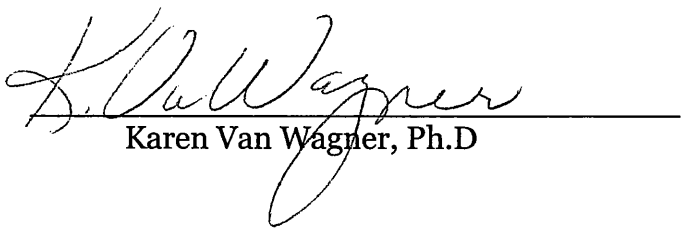
5. Requiring NTSP either to choose not to be involved in contracting or to sign and messenger all payor contracts effectively blocks NTSP from focusing its resources on its spillover business model, therefore presenting a significant danger to NTSP's reputation and continued viability as well as hurting NTSP's efforts to increase efficiency and quality of health care. Further, requiring NTSP to messenger all payor contracts or preventing NTSP from terminating payor contracts it has, regardless of payor breaches of contract or illegal conduct, exposes NTSP to liability and deprives it of its rights under its contracts.

6. Requiring NTSP to notify physicians and payors of the Final Order and Complaint and restricting the manner and content of NTSP's communications will affect communications between NTSP and the participating physicians and Metroplex payors. Further, to comply with the order, NTSP will have to change its current policies regarding entering into, messengering, and terminating contracts, as well as seek new Physician Participation Agreements with each of its 550 physicians. If the order were reversed on appeal, NTSP would have to again change its contracting policies, seek to reinstate the rescinded Physician Participation Agreements, and, to the extent it could, undo the effects of the actions taken under the order. This would be costly and likely confusing to physicians and payors.

7. The contracts discussed by Complaint Counsel at the hearing have been terminated, replaced, or are already terminable-at-will by the payor. NTSP does not have a current contract with Aetna. The Cigna contract has been terminable-at-will since September 2004. NTSP's contract with United was replaced in 2005.

This declaration supplements the testimony I have already given in this proceeding.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct and that this declaration was executed on December 20, 2005, at Fort Worth, Texas.



Karen Van Wagner, Ph.D

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L

NTSP
North Texas Specialty Physicians
1704 River Run, Suite 210
Fort Worth, Texas 76107
817-810-5208
FAX: 817-332-3614

TO: Jim Sabolik

FAX #: 214-200-8447

FROM: Dave Palmisano, Director of Managed Care

DATE: June 18, 1999

PAGES: 19 (including cover)

Please contact Becky at 817-332-8847 if you do not receive all pages of this fax.

MESSAGE:

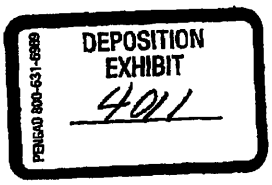
Jim:

The following is the lawsuit filed on June 10, 1999, for your information. It is important to understand that this lawsuit is in no way directed towards Aetna as we believe Aetna is simply a third party regarding this matter as the agreement in dispute was with Harris Methodist Select.

We look forward to hearing back from you to begin scheduling the respective PSN meetings. Call me if you have any questions at 817-810-5208.

Thanks have a great weekend!

Dave Palmisano



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CAUSE NO. _____

Mark F. Collins, M.D., William S. Vance, M.D., Howard L. Shaffer, M.D., Howard L Shaffer, P.A., Warren Wilson, M.D., NORTH TEXAS SPECIALTY PHYSICIANS, Individually and as Class Representatives,	§	IN THE DISTRICT COURT
Plaintiffs	§	[CLASS ACTION]
VS.	§	TARRANT COUNTY, TEXAS
HARRIS METHODIST SELECT, MEDICAL SELECT MANAGEMENT and HARRIS METHODIST HEALTH SYSTEM,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE COURT:

Plaintiffs Mark F. Collins, M.D., William S. Vance, M.D., Warren Wilson, M.D., Howard L. Shaffer, M.D., Howard L. Shaffer, P.A., and North Texas Specialty Physicians, Individually and as Representatives of the Class defined herein, file their Original Petition and for cause of action would show the Court as follows:

DISCOVERY PLAN

1. Plaintiffs intend that discovery be conducted under Rule 190.4, Level 3.

PARTIES

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2. Plaintiffs Mark F. Collins, M.D., William S. Vance, M.D., Warren Wilson, M.D., and Howard L. Shaffer, M.D. are physicians who practice medicine in Tarrant County, Texas.

3. Dr. Shaffer practices medicine through his professional association, Howard L. Shaffer, P.A., which has its principal place of business in Tarrant County, Texas.

4. Plaintiff North Texas Specialty Physicians ("NTSP") is a Texas non-profit corporation organized under section 5.01(a) of the Texas Medical Practice Act. It is comprised of specialist physicians practicing in Tarrant County, Texas.

5. Defendant Harris Methodist Select ("Harris Select") is a Texas non-profit corporation organized under 5.01(a) of the Texas Medical Practice Act with its principal place of business in Tarrant County, Texas. It may be served with process through its registered agent, Ramiro D. Cavazos, 750 Eighth Avenue, Suite 600, Fort Worth, Texas 76104-2597.

6. Defendant Medical Select Management ("MSM") is a non-profit corporation doing business in the State of Texas. On information and belief, MSM is the successor to Harris Select, and the two shall be referred to hereinafter collectively as "Select." It may be served through its registered agent, Ramiro Cavazos, M.D. 750 Eighth Avenue, Suite 600, Fort Worth, Texas 76104-2597.

7. Defendant Harris Methodist Health System ("System") is a non-profit corporation doing business in the State of Texas and having its principal place of business in Tarrant County, Texas. System was the institutional member of Harris Select. System may be served with process through its registered agent, David L. Pinkerton, 6000 Western Place, Suite 340, Fort

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Worth, Texas 76107.

VENUE

8. Venue is proper in Tarrant County, Texas since part or all of the cause of action accrued in Tarrant County, Texas.

INTRODUCTION

9. In the face of the new healthcare environment, the Harris Methodist Health System developed an interrelated network of companies that reach out across the full spectrum of health-related services. Through this network, System has competed with traditional insurance companies and has captured a huge share of the HMO market in Tarrant and surrounding counties.

10. System used one of its companies, Select, to organize and control physicians and physician groups. Neither System nor Select provides any healthcare services directly. They are two purely administrative organizations. The ostensible purpose of Select was to act as agent for and on behalf of area physicians in negotiating with various HMOs and other such purchasers of healthcare services ("Payors"). The loyalty and duty of Select was to be to the physicians for whom they were supposed to be negotiating. In return, Select received a portion of contract payments from Payors for the services provided by those physicians. Unfortunately, it turns out that the loyalty of Select is to itself and/or the System network, to the detriment of the physicians that Select was supposed to be representing.

11. Defendants have historically used their control of the vast share of the local market of "lives" to force increasingly burdensome and restrictive "take it or leave it" contracts on

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physicians. However, even when agreements are reached, if, as a result of over aggressive marketing, ever increasing overhead, mismanagement, or a combination thereof, Defendants determine that they cannot profit enough, they simply abandon and ignore their prior agreements with physicians and tell physicians that the previous terms of an agreement are "off" and mandate changes and more restrictive terms that are more profitable for Defendants. In summary, as Defendants have attempted to capture a larger and larger share of the market, they have built their empire on the backs of local physicians rather than addressing and reducing their own internal operations.

12. This is one of the cases of the Defendants at first reaching an agreement with a group of area physicians and later backing out of that agreement for their own benefit and simply refusing to meet the obligations they had originally agreed to.

FACTS

13. The revolutionary changes in the health care field over the past decade have spawned many novel market arrangements. Perhaps the most significant development is the ascendency of managed-care driven health maintenance organizations ("HMOs") and their affiliates, whose hold over a large number of subscribers has permitted them to wield considerable economic power over health care providers.

14. System exerted this power in 1993 when it formed an affiliate to assist in administrative aspects of the managed health care industry while at the same time receiving funds (and profits) at another level of the managed health care chain. This new entity, Select, was ostensibly designed and promoted to assist physicians and their professional associations in contracting with Payors. Specifically, Select was to negotiate fees and other terms of managed

care contracts for the physicians and was intended to be a buffer between managed care providers and the physicians.

15. Although Select was formed as a non-profit corporation under the guise that it was to provide, among other things, scientific research, support for medical education through grants and scholarships, and delivery of health care to the public, System was its only member, and Select, like most companies, strived to make a profit, which could then be funneled to System. System, through its various corporate devices, has controlled every aspect of Select and the employees who implement them. Senior officers for System worked for Select. System's control over Select has been maintained through a variety of means, including, but not limited to:

a. Veto over election of all directors for Select;

b. Interlocking and overlapping employees and officers;

c. Interlocking and overlapping financial arrangements among Defendants;

d. Directing and controlling the policies and actions of Select; and

e. Directing and controlling all financial transactions including distributions of any profits.

As is evident, Defendants are or have been, in reality, a single business enterprise. They are and were acting as a tight-knit partnership, having a symbiotic relationship, depending upon one another and sharing the profits of the operation. Employees of System and Select work or have worked together, without regard for these ostensible entity distinctions, to advance the common purpose of Defendants.

16. Select promoted itself to physicians in the Tarrant County area as being their agent that would solicit and negotiate fees and other terms of managed care contracts on behalf of and in the best interest of the physicians and professional associations who signed up with it. The

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physicians in turn trusted Defendants to act in their best interest and allowed Select to negotiate on their behalf. As a result, Defendants had a fiduciary and special relationship with those physicians and professional associations who signed up with Select.

17. Defendants' plan was to recruit physicians and their professional associations as "participating providers" through a Participating Provider Services Agreement ("PPSA") and then market its "panel" of physicians to Payors (participating providers and their professional associations, including each Plaintiff and Class Member, will hereinafter be referred to as "Select Physicians"). Defendants would then negotiate with Payors on behalf of the Select Physicians to arrive at an agreement that included the amount Select Physicians would receive for certain medical services provided to that Payors' members and an amount Defendants would receive. Once Defendants reached an agreement with a Payor, Select was to then give the Select Physicians notice of the contract through a "Payor Offer" and summarize the material terms of the contract. If agreed to, the Payor Offer became an amendment to the PPSA.

18. Because of Defendants' strong presence in Tarrant County and the understanding that Select was a System affiliate and had the exclusive contract to arrange contracts for medical services for Harris HMO members, Plaintiffs (the term Plaintiff throughout is intended to mean the named representative Plaintiffs and each member of the defined class), as well as similarly situated physicians and professional associations in the Tarrant County area, felt compelled to join Select and sign a PPSA. Plaintiffs also joined Select because they relied on Defendants' representations that Select would work *for* and in the interest of the Select Physicians in negotiating favorable contracts with Payors and help direct those physicians through the labyrinth of managed health care. It is believed that approximately 2000 of the health care providers in the

Tarrant County area entered PPSAs with Select.

19. In October 1994, Select entered into a Letter of Agreement with Aetna affiliates (all Aetna affiliates and related companies involved in the various transactions set out herein, including, but not limited to, Aetna Health Management, Inc., Southwest Health Plan, Inc., Aetna Health Plans of North Texas, Inc. d/b/a Aetna U.S. Healthcare shall be hereinafter referred to collectively as "Aetna") whereby the parties agreed that Select would provide or arrange for the provision of medical services for Aetna's insured members in Tarrant County (the "1994 Agreement"). The 1994 Agreement also specified that Select would be the "Exclusive Physician Network" for Aetna's members in the Tarrant County area for a limited period of time, and it set forth the fees that would be paid to Select Physicians for certain services. The exclusivity period was to become effective "no later than March 1, 1995, and will terminate on the first day of the eighteen (18) month Transition Period." Aetna agreed to use its best efforts to cause the exclusivity provisions to be effective as soon as possible after January 1, 1995.

20. The 1994 Agreement also provided for a specific term:

> [Select] shall provide the services commencing January 1, 1995, and ending on the last day of the "Transition Period." The Transition period is an eighteen (18) month period that may commence at any time after December 31, 1997, upon sixty (60) days' prior written notice delivered by either party to the other that it is terminating the Provider Agreements.

Accordingly, the 1994 Agreement ran from January 1, 1995, to a date no earlier than July 1, 1999.

21. Pursuant to the 1994 Agreement, two Notices of Payor Contract Offer -- one for Aetna's PPO product and one for Aetna's HMO product -- (the "1994 Payor Offers"), were presented to the Select Physicians. The 1994 Payor Offers were prepared by Defendants and

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included the key terms of the 1994 Agreement, including specific fee schedules and the following term:

> The agreement may be terminated by either party with eighteen months notice anytime after December 31, 1997, which provides a minimum term of four and one-half years.

and;

> Harris Methodist Select is the exclusive network provider of Aetna's physician care in Tarrant County.

Plaintiffs relied on the representations made by Defendants in the 1994 Payor Offers, especially with respect to the fee schedules, terms and the exclusivity in accepting them.

22. Under the 1994 Aetna HMO Payor Offer, Aetna was to pay a capitated fee to Select based on the number of Aetna members who had designated a Select Physician as their primary care physician ("PCP"). Select was to then distribute a portion of these funds to the Select Physicians who did not opt out of the 1994 Payor Offers, and Defendants retained a portion of the capitated fee for themselves. Select was also paid an administrative fee under the HMO Payor Offer based on the number of members in the area. Under the Aetna PPO Payor Offer, the parties agreed upon a set fee schedule for Select Physicians, and Aetna was to pay a Select Physician directly for any services performed in accordance with the fee schedule established by Aetna and Select. Thus, Defendants derived income only from Select's share of the Aetna HMO services and received nothing from the PPO services.

23. Relying on Defendants' representations of the 1994 Agreement in the 1994 Payor Offers, Plaintiffs, and other similarly situated physicians described below as Class Members, accepted both of the 1994 Aetna Payor Offers despite the fact that fees for services were considerably less than Select Physicians had received for the same services in the past.

Specifically, Plaintiffs accepted these 1994 Payor Offers because the fee schedule was satisfactory, the contracts were exclusive and were guaranteed for at least 4 ½ years (i.e. at least until July 1, 1999). Select Physicians (including Plaintiffs) thereby became the Exclusive Physician Network for Aetna's insured members in Tarrant County and were able to continue to treat their patients who were Aetna insured members.

24. Unbeknownst to Plaintiffs, Defendants began losing money operating under the 1994 Agreement. Thus, in the Spring or Summer of 1997 Defendants secretly agreed with Aetna to renegotiate the 1994 Agreement, even though the 1994 Agreement could not be terminated until July 1999 at the earliest by its terms. The newer contract that resulted from their negotiations (the "1997 Agreement") paid Select much more for its purely administrative function and the Select Physicians much less for their actual medical services than under the 1994 Agreement. Aetna's overall financial return on the HMO plan and PPO plan was increased, and Select's financial return under the HMO portion increased. The only way this could be accomplished to the benefit of Aetna and Select was to severely reduce payments to the only people actually providing medical care -- the Select Physician Network for Aetna's insured members. The 1997 Agreement, unlike the 1994 Agreement and 1994 Payor Offers, also required a Select Physician to accept both the new Aetna PPO Payor Offer and the new Aetna HMO Payor Offer -- a physician could not participate in one and not the other.

25. Aetna and Defendants negotiated the 1997 Agreement and agreed to cancel the 1994 Agreement in secret, without the knowledge or consent of Select Physicians, who were the third-party beneficiaries of the 1994 Agreement. Select Physicians did not learn that Defendants had renegotiated Select's agreement with Aetna until after the fact. At that time, Defendants

notified the Select Physicians "of an impending change in your contract with Aetna" and that the renegotiation was done "[i]n an effort to extend the current Select agreement with Aetna [i.e. the 1994 Agreement] *which expires December 31, 1997.*" Defendants' representation to the Select Physicians of the termination date of the 1994 Agreement was false, as the earliest the 1994 Agreement could have terminated under its terms would have been July 1999. However, Plaintiffs later learned that Select's exclusivity agreement with Aetna *did* end December 31, 1997. The limit of the exclusivity period was not conveyed to Select Physicians by Select in the 1994 Payor Offers or in the summaries thereof prepared by Select.

26. It was not until July 8, 1997, that Select Physicians learned the specifics of those portions of the 1997 Agreement that related to the Select Physicians. They learned this information when they received from Select two new Notice of Payor Contract Offers: one for the Aetna HMO product and one for the Aetna PPO product (collectively referred to as the "1997 Payor Offers"). To protect their own financial interests at the expense of the Select Physicians, Defendants chose to terminate a contract that was favorable to the Select Physicians and replace it with one that was considerably less favorable to the physicians, but much more favorable to Defendants.

27. Plaintiffs were asked to accept or reject the 1997 Agreement within 15 days of receiving it. After receiving an extension of time to properly analyze the 1997 Payor Offers, Plaintiffs, and other similarly situated Class Members defined below, informed Select on September 19, 1997, that their contract with Select with respect to the 1994 Agreement was still in effect, and that they expected to continue to be paid under the 1994 Payor Offer rates. Despite Plaintiffs' response, Select and Aetna began paying Plaintiffs the lower rates set forth in the 1997

Agreement, beginning July 1, 1997, under protest by Plaintiffs. Of course, Plaintiffs, and other similarly situated Class Members, continue to treat their patients who are Aetna members because Plaintiffs do not believe that the medical care provided to their patients should be compromised just because Defendants are not living up to the terms of the obligations they agreed to.

28. Plaintiffs repeatedly complained to Defendants about the Defendants' failure to live up to the obligations everyone had agreed to in the 1994 Payor Agreements. Defendants responded to Plaintiffs' demands and complaints with stall tactics. Finally, in November 1997, Plaintiffs, through their agent, NTSP, met with representatives of Defendants to discuss the Aetna contracts again. The meeting concluded with Defendants offering Plaintiffs new terms -- different from those found in the 1997 Payor Offers. The new terms were documented in a Memo of Understanding, but the agreement could not be finalized until Defendants received confirmation from Aetna that the terms were acceptable. That confirmation was supposedly received by Defendants shortly thereafter, so Plaintiffs asked Defendants to begin preparing a proposed contract to formalize a new agreement.

29. Since that time, Defendants have again responded with stall tactics, refused to live up to the new agreement, and continued to refuse to live up to their obligations agreed to in the original 1994 Payor Offers. Plaintiffs more recent demands for Defendants to abide by the 1994 Payor Offers have also been rejected. Plaintiffs are thus left with no alternative but to bring these claims against Defendants individually, as well as on behalf of the Class Members described below.

CLASS ALLEGATIONS

30. This action is brought and may properly be maintained as a class action pursuant to

the provisions of Rule 42(b)(1) and (4) of the Texas Rules of Civil Procedure. Plaintiffs bring this action, on behalf of themselves and others similar situated, as representative members of the following proposed class:

> All Physicians and their Professional Associations or Practice Groups (including their successors, agents and assigns) who are or were members of North Texas Speciality Physicians and who had or have 1994 Payor Offer agreements with Select related to any Aetna related health plan and/or have or had a Participating Provider Services Agreement with Harris Methodist Select or Medical Select Management.

31. Excluded from the class is each Defendant, any entity or person who has a controlling interest in Defendants' operations; and any entity in which Defendants have a controlling interest.

32. The class of the Select Physicians and their Professional Associations or Practice Groups (including their successors, agents and assigns) who are or were members of North Texas Speciality Physicians and who had or have 1994 Payor Offer agreements with Select related to any Aetna related health plan and/or have or had a Participating Provider Services Agreement with Harris Methodist Select or Medical Select Management ("Class Members") are so numerous that joinder of all Class Members is impracticable under the standard of Tex. R. Civ. P. 42. At this time the number of Class Members is believed to be in excess of 200.

33. Common questions of law and fact exist as to all Class Members and predominate over any questions affecting only individual Class Members. Among the questions of law and fact common to the Class include the following:

- Whether Defendants violated their fiduciary duty and duty of good faith and fair dealing to Class Members;
- Whether Defendants' premature termination of the 1994 Agreement and

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renegotiation with Aetna of the 1997 Agreement and their refusal to abide by the obligations they had originally agreed to breached their 1994 Payor Offers with Class Members;

- Whether Defendants made misrepresentations to Class Members about the Aetna agreements and Payor Offers;
- Whether or not Defendants acted negligently; and
- Whether the acts or omissions of Defendants were done willfully, maliciously, fraudulently, wantonly, oppressively or with an entire want of care and with conscious indifference.

34. Plaintiffs' claims are typical of the claims of the Class Members, as all such claims arise out of their membership in Select and NTSP and the injury they suffered arising out of Defendants' common course of conduct as alleged herein.

35. Plaintiffs, as class representatives, will fairly and adequately protect the interests of the class, have no interest antagonistic to the Class Members, and will vigorously prosecute the claims in this action, have retained competent and experienced class litigation counsel, have secured financial arrangements sufficient to fund the class action, and have no interests antagonistic to or in conflict with Class Members.

36. The prosecution of separate actions by individual members of the class would create a risk of inconsistent adjudications with respect to individual members of the class, which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests. Prosecution

of separate actions by individual members of the class would also establish incompatible standards of conduct for the party opposing the Class Members.

37. By contrast, the conduct of this action as a class action presents fewer management difficulties, conserves the resources of the parties and the court system, and protects the rights of each Class Member. Notice of the pendency and any resolution of this action can be provided to the Class Members by a combination of publication and individual notice, based upon records maintained by Defendants and NTSP.

38. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the class is impracticable and the questions of law and fact common to the members of the class predominate over any questions affecting only individual members. There will be no real difficulty in the management of this action as a class action.

CAUSES OF ACTION

BREACH OF FIDUCIARY DUTY

39. As evidenced by the PPSA, the duties and obligations set forth therein and described above, a special relationship of confidence and trust existed between Defendants and the Select Physicians. Select was promoted to Plaintiffs as being their agent who would negotiate with Payors on their behalf. In fact, Select did so on behalf of Plaintiffs with other payors prior to the 1994 Payor Offers. Therefore, a relationship of trust and confidence, and thus a fiduciary relationship, existed at the time Plaintiffs entered into the 1994 Payor Offers. Plaintiffs were justified in relying on Select to act in their best interest and to place their trust and confidence in Select when they considered the 1994 Payor Offers. Plaintiffs trusted the representations made by

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Defendants in the 1994 Payor Offers and relied upon them in accepting the offers and becoming the Exclusive Physician Network for Aetna's insured members in Tarrant County.

40. Despite their fiduciary duty, Defendants failed to act in the best interest of Plaintiffs with regard to the 1994 Agreement and the 1994 Payor Offers and when given the opportunity, Defendants renegotiated the 1994 Agreement with Aetna before the agreement's permissible termination date in a manner that was to Defendants' advantage and Plaintiffs' detriment. Moreover, they did so in secret without notifying or obtaining agreement of Plaintiffs in advance. Defendants also breached their fiduciary duty in negotiating the Payor Offers and by failing to properly disclose the material terms of the agreements in the Payor Offers.

41. Plaintiffs were damaged as a result of Defendants' actions because the compensation they received for services rendered after July 1997 was much less than the fees they had agreed to as prescribed in the 1994 Payor Offers, which were to be in effect at least until July 1999. Plaintiffs thus seek these damages from Defendants in an amount that is within the jurisdictional limits of the Court. Plaintiffs also contend that Defendants' actions were done willfully and maliciously with the intent to bring financial benefit to Defendants at the expense of Plaintiffs and other Select Physicians or with reckless disregard and conscious indifference to Plaintiffs and Select Physicians.

BREACH OF DUTY OF GOOD FAITH AND FAIR DEALING

42. For the reasons explained above, Defendants also owed Plaintiffs the duty of good faith and fair dealing. Defendants breached this duty with regard to the 1994 Agreement and the 1994 Payor Offers when they renegotiated the 1994 Agreement with Aetna before the agreement's permissible termination date in a manner that was to Defendants' advantage and to

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Plaintiffs' detriment. Defendants also breached this duty in negotiating the Payor Offers and by failing to properly disclose the material terms of the agreements in the Payor Offers.

43. Plaintiffs were damaged as a result of Defendants' actions because the compensation Plaintiffs received for services rendered after July 1997 was much less than the fees prescribed in the 1994 Payor Offers, which were to be in effect until at least July 1999. Plaintiffs thus seek these damages from Defendants in an amount that is within the jurisdictional limits of the Court. Plaintiffs also contend that Defendants' actions were done willfully and maliciously with the intent to bring financial benefit to Defendants at the expense of Plaintiffs and other Select Physicians or with reckless disregard and conscious indifference to Plaintiffs and Select Physicians.

BREACH OF CONTRACT

44. The PPSA between Defendants and Plaintiffs provides that any terms of a Payor Offer that are accepted by the Select Physician and are inconsistent with the PPSA amend and supersede the PPSA. When Defendants entered into the 1994 Agreement with Aetna, it operated as a general contract. Defendants then sent the 1994 Payor Offers to Plaintiffs pertaining to the 1994 Agreement, and Plaintiffs' acceptance of these Payor Offers operated as subcontracts. These subcontracts incorporated many of the same terms and conditions of the 1994 Agreement, including the termination provision. Because that provision was inconsistent with the termination provision in the PPSA, the provision in the Payor Offer/1994 Agreement controlled. Defendants were therefore unable to terminate the subcontracts with Plaintiffs until at least July 1999. Nevertheless, Defendants informed Plaintiffs that they were terminating the 1994 Payor Offers in July 1997 and breached those subcontracts by causing Plaintiffs to cease being paid under the rates or fee schedules established in the 1994 Payor Offers. Defendants thus breached both the

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PPSA and the 1994 Payor Offers. Plaintiffs have been damaged as a result of Defendants' breach in an amount that exceeds the minimum jurisdictional limits of this Court.

MISREPRESENTATION

45. Defendants made misrepresentations to Plaintiffs or omitted and concealed information regarding the matters set forth in this Petition concerning material facts related to the PPSAs, the Aetna contracts and the Payor Offers described herein. Such misrepresentations and omissions were made by Defendants in the course of Defendants' business and in transactions in which Defendants had a pecuniary interest for the guidance of Plaintiffs in their business transactions. In this connection, Defendants purported to have, and did have, superior knowledge concerning the subject matter related to the misrepresentations and/or omissions. When Defendants made such misrepresentations or omissions, Defendants either knew they were false or made them recklessly and/or negligently. In the alternative, Defendants did not exercise reasonable care or competence in obtaining, communicating or omitting the information. Defendants made such statements and/or omissions with the intent of inducing Plaintiffs to enter into the transactions described herein and such statements and/or misrepresentations were relied upon by Plaintiffs to Plaintiffs' substantial injury and damage in an amount far in excess of the minium jurisdictional limits of the Court.

46. By reason of the fact that Defendants knew that the misrepresentations were false and the omissions were material or acted with reckless disregard thereto, the actions of Defendants were willful and malicious and constitute conduct for which the law allows the imposition of exemplary damages.

NEGLIGENCE

47. Defendants owed a duty to Plaintiffs to exercise reasonable care in negotiating, summarizing, conveying and dealing with managed care contracts on behalf of Plaintiffs. Defendants breached the duty owed to Plaintiffs in those matters with regard to the 1994 and 1997 Agreements and the 1994 and 1997 Payor Offers.

48. As a direct and proximate result of Defendants' conduct, Plaintiffs sustained substantial injury and damage in an amount far in excess of the minium jurisdictional limits of the Court. Plaintiffs also contend that Defendants' actions were done maliciously with the intent to bring financial benefit to Defendants at the expense of Plaintiffs and other Select Physicians or with reckless disregard and conscious indifference to Plaintiffs and Select Physicians.

DAMAGES

49. As a result of Defendants' breaches and wrongful conduct, Plaintiffs have been damaged in an amount that is within the jurisdictional limits of this Court. Specifically, Plaintiffs have been damaged by the difference between the amounts due to them for services provided to Aetna's insured members under the 1994 Payor Offers less the amounts Defendants have already paid Plaintiffs for services provided to Aetna's insured members. Plaintiffs are specifically alleging that all such Defendants are being sued jointly and severally.

ATTORNEY'S FEES

50. Because of Defendants' breach and wrongful conduct, Plaintiffs have been compelled to hire Thompson & Knight, P.C. to prosecute this action on their behalf, and Plaintiffs have agreed to pay a reasonable fee for those services. Pursuant to section 38.001 of the Civil Practice & Remedies Code, Plaintiffs are entitled to recover their attorneys fees in this action because it involves claims pertaining to a breach of contract. Plaintiffs are also entitled to recover attorneys fees and costs in this action should they prevail, pursuant to paragraph 8.12 of the

PPSA.

For these reasons, Plaintiffs ask that Defendants be cited to appear and answer herein, and that on the trial of this matter, Plaintiffs receive judgment against Defendants for all damages in an amount within the jurisdictional limits of this court, attorneys fees, prejudgment interest and post-judgment interest, punitive damages and such other relief to which they may be entitled.

Respectfully submitted,

THOMPSON & KNIGHT, P.C.

By: _____

E. Michael Sheehan
State Bar No. 18174600

Jennifer P. Henry
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ATTORNEYS FOR PLAINTIFFS

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Q You mentioned prompt pay. What is that?

A Well, that's another whole contractual discussion point that really gets quite a bit of attention. Prior to, again, the Texas legislature stepping in and defining quite -- quite a bit more clearly what prompt pay means in the State of Texas, prior to that legislation taking effect, prompt pay was pretty much whatever the contract really wanted to say, and you had to sit down and make sure you understood what each part of the prompt pay definition meant for each payor that came to you and said here's what I mean by prompt pay.

Q Has NTSP run into difficulties with payors concerning prompt pay?

A Yes.

Q Can you tell me which payors?

A CIGNA, Aetna, MSM, United to some degree, Blue Cross on our -- on the PPO as well as some of the -- several of the smaller PPO companies.

Q Has NTSP had occasion to actually commence litigation over prompt pay?

A Oh, yes. Yes, we have.

Q In what circumstances?
A We instituted a class action suit against MSM for inappropriate payment, lack of paying promptly.
Q When was that lawsuit filed?
A Mid-1999.
Q And who was sued?
A MSM, Harris Methodist Select that became MSM.
Q And where was that suit filed?
A Here in Tarrant County.
Q And you indicated that that was a class action, is that correct?
A It was filed as a class action, yes.
Q What role did NTSP seek as part of that class action?
A Well, we didn't seek a role. The physicians came to us that were parties to a 1994 contract between themselves and MSM and said -- and basically informed us of the difficulties they were having with that contract. At that time, we were discussing risk contracts with both MSM -- for both Aetna and Harris with MSM.
MR. ZANG: Objection, Your Honor, relevance and hearsay.

Q Was there any other contractual disputes that NTSP had with CIGNA?

A We -- we had several contract implementation problems with how the fee schedules were loaded. There would be a change in the fee schedule as called for by the contract. CIGNA would acknowledge that, indeed, the -- the change was appropriate and then 60 to 90 days later, we would find when we received the EOBs that, indeed, the change had never occurred.

Q What is an EOB?

A Explanation of benefits. It -- it accompanies the checks you get from a plan.

Q Please state whether or not NTSP considered that to be a breach of contract.

A We did.

Q Did NTSP take any steps concerning that breach?

A We did.

Q What steps did you take?

A We brought it to CIGNA's attention and asked for them to resolve it on both the HMO and the PPO.

Q Did they do so?

A In the long run they did, yes.

Children don't use a lot of health care services. We don't provide that -- that element of the risk distribution is not part of our patient population because we only do adults, and I say "only." With rare exceptions, do adults. Our population is -- doesn't index to 1, it indexes to 1.1. In some cases, it's been as high as 1.17.

Q We were talking about the dispute between -- I'm sorry, you were talking to Complaint counsel about the dispute between CIGNA and NTSP about using current rates. Do you recall that?

A I do.

Q Was there a contract in place between CIGNA and NTSP that required current rates?

A We believe so, yes.

Q Which one was that?

A It would have been -- well, that -- that was my point of confusion. I'm not sure what amendment to the LOA might have covered that, but it came out of our discussions on one of those instances.

Q Was the dispute that was going on between CIGNA and NTSP about using current RBRVS a contractual dispute?

A Yes, sir.

MR. HUFFMAN: Your Honor, you'd asked what the deposition exhibits were for Dr. Van Wagner. That would be CX1194 through CX1197.

JUDGE CHAPPELL: Thank you.

MR. HUFFMAN: That's all the redirect I have, Your Honor.

JUDGE CHAPPELL: Any recross based on redirect?

MR. ZANG: No, Your Honor.

JUDGE CHAPPELL: Thank you, ma'am. You're excused.

(The witness stood aside.)

JUDGE CHAPPELL: Next witness?

MR. HUFFMAN: Yes, Your Honor, I'd like to call Dr. Robert Maness to the stand.

Oh, I'm sorry. Before we do that, we have an exhibit matter before we call him.

JUDGE CHAPPELL: All right.

MR. KATZ: I just wanted to make it clear for the record, Your Honor, in preparation for Dr. Maness' testimony, there's some exhibits that had not yet been admitted into evidence. We provided a copy to Complaint counsel. They have

N

Exhibit N

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[PUBLIC RECORD]

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

IN THE MATTER OF NORTH TEXAS SPECIALTY PHYSICIANS, A CORPORATION.	**Docket No. 9312**

DECLARATION OF PAUL GRANT, M.D.

STATE OF TEXAS §
§
COUNTY OF TARRANT §

I, Paul Grant, M.D., do hereby declare and state as follows:

1. I am over the age of eighteen (18) years, am of sound mind, have never been convicted of a felony or a crime involving moral turpitude, and am in all other ways fully competent to make this declaration. I have personal knowledge of the facts set out herein and they are true and correct.

2. I am the Vice President of the Board of North Texas Specialty Physicians ("NTSP") and Chairman of the Finance Committee. As Vice President and Chairman of the Finance Committee as well as a participating physician of NTSP, I am familiar with the general business operations and contracting practices of NTSP, the relationship between NTSP and its participating physicians, and the effect of NTSP's contracting practices on the participating physicians.

3. If NTSP is required to terminate the non-risk contracts that are made available through NTSP to its participating physicians, that will also terminate each participating physician from the contracts. This termination will disrupt the physicians' medical practices as well as the operation of health plans

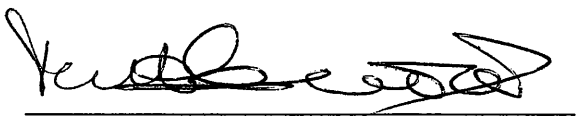
and patient care covered by these contracts. Further, termination of these contracts will cause financial harm to the participating physicians.

4. If NTSP were to terminate their contracts, thousands of patients would, depending on their health care plan, either have no access to certain physician services or have access to those physician services at a substantially increased cost to the patient. These patients' non-access or limited access to physician services will cause financial harm to the physicians and patients as well as affect health plan networks and patient care.

5. Requiring NTSP either to choose not to be involved in contracting or to sign and messenger all payor contracts effectively blocks NTSP from focusing its resources on its spillover business model, therefore presenting a significant danger to NTSP's reputation and continued viability as well as hurting NTSP's efforts to increase efficiency and quality of health care. Further, this restriction on NTSP's contracting and prevention of the effective operation of a spillover model will adversely affect physician relationships with each other and with payors and also will adversely affect patient care.

This declaration supplements the testimony I have already given in this proceeding.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct and that this declaration was executed on December 20, 2005, at Fort Worth, Texas.



Paul Grant, M.D.

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per thousand, are we talking about hospital days?

A Yes.

Q All right. Is PacifiCare right now trying to grow its network in Tarrant County?

A Yes.

Q Okay. How are you going about trying to grow your network here in Tarrant County?

A One would be through NTSP. One would be taking a list of available doctors through the board of Medical Examiner's website, targeting them directly, sending contracts through the mail, following up.

Q Okay. But you would view NTSP as a part of how you'd go about growing your network in the metroplex?

A Yes.

Q Are you looking at this time to expand or contract or maintain the same relationship with NTSP?

A Maintain the same.

Q Have you ever considered or referred to NTSP as your top performer in the metroplex?

A Yes.

Q And has that been -- been true?

A Yes, in the overall context, yes.

similar reports like this?

A Right.

Q Do you know if anyone within PacifiCare has ever raised any questions about the reliability of the data provided in Exhibit RX1846 or similar type documents?

A No.

Q Let me back up and ask you a follow-up question.

You talked earlier about NTSP being your top performer in the metroplex. I want to make sure I'm clear. Were you talking about risk, fee-for-service or both on an overall basis?

A Say on an overall basis.

Q So that would be both for risk and for fee-for-service?

A Yes.

MR. KATZ: That's all the questions I have at this time, Your Honor.

JUDGE CHAPPELL: Cross?

MR. WIEGAND: Yes, Your Honor.

JUDGE CHAPPELL: Go ahead.

Q

along.

BY MR. AGARWAL:

Q Mr. Roberts, were Aetna's costs affected by the termination of the contract with NTSP?

A I can't answer that question about that single entity.

Q Why can't you answer that question?

A Because over that same one-year period, we also had 1200 physicians that were in the process of changing reimbursement structures as well, so we never went back to determine if the 1200 physicians were the driver of the changes in those costs or the 200 that were part of NTSP.

MR. AGARWAL: Your Honor, if I could just have a moment to confer with counsel?

JUDGE CHAPPELL: Go ahead.

BY MR. AGARWAL:

Q And, Mr. Roberts, does Aetna currently have a contract with NTSP?

A No.

MR. AGARWAL: Nothing else at this time, Your Honor.

JUDGE CHAPPELL: Cross-exam?

MR. HUFFMAN: Yes, Your Honor.

R

Exhibit R

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UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: Deborah Platt Majoras, Chairman
Thomas B. Leary
Pamela Jones Harbour
Jon Leibowitz

In the Matter of North Texas Specialty Physicians, a corporation.	Docket No. 9312

ORDER GRANTING MOTION FOR STAY OF FINAL ORDER PENDING JUDICIAL REVIEW

North Texas Specialty Physicians ("NTSP") has moved that the Commission grant a stay of the Final Order issued in this proceeding pending judicial review of the Commission's decision. NTSP is filing a petition for review of the Commission's decision in the U.S. Court of Appeals for the Fifth Circuit. The Commission has determined to grant NTSP's motion. NTSP has made the requisite showing under the four factors the Commission is to consider in granting a stay: likelihood of success on appeal, irreparable harm absent a stay, lack of harm to others if a stay is granted, and that the stay is in the public interest.

Accordingly,

IT IS ORDERED THAT the Final Order entered by the Commission on November 29, 2005, is hereby stayed effective upon NTSP's filing of a petition for review and remaining in effect until 90 days after the U.S. Court of Appeals for the Fifth Circuit vacates the Final Order or otherwise issues a decision ruling on the petition for review.

By the Commission.

Donald S. Clark
Secretary

ISSUED: December __, 2005