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COMPETITION AND LAW POLICY

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P R O C E E D I N G S

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MR. BYE: If we might start now, I'd like to welcome you back to this morning's hearings on health care and competition and law policy. My name is Matthew Bye from the Federal Trade Commission, and I'm joined this morning with my co-moderator, June Lee, from the Department of Justice Antitrust Division.

Today's topic is physician market definition. We'll be looking at a range of empirical and theoretical questions and also examining some of the issues associated with barriers to entry in physician markets.

Today's hearing is noteworthy for two reasons. First is it's the home straight for this year's health care hearings. We started in February, and we will conclude next week. It's also significant that we have six expert panelists, many of whom have traveled great distances to join us today.

I would like to briefly introduce them in the order that they will present. Complete bios are available in the handouts which are outside. Once I've introduced the panelists, we'll start with the presentations and then toward the end of the session move to a moderated panel discussion.

Our first speaker this morning is John Wiegand, who's an antitrust lawyer and litigator working primarily on health care-related cases in the FTC's San Francisco office.

Next we have Margaret Guerin-Calvert, who's a co-founding principal of Competition Policy Associates and spent many years at the Antitrust Division of the Department of Justice.

David Argue works with Economists, Inc., and is experienced in a number of hospital and physician mergers.

Monica Noether is a vice president of the Charles River Associates in Boston, where she heads the competition practice and deals with a range of health care cases.

Howard Feller leads the antitrust practice group for McGuire, Woods and chaired the health care committee of the ABA's Antitrust Section as well as edited the group's Antitrust Health Care Chronicle.

Our last speaker will be Astrid Meghrigian, who is counsel for the California Medical Association and has extensive background in a range of physician matters.

John, would you like to start?

MR. WIEGAND: Sure. Thank you, Matthew.

Good morning. First, for the record, the views I am expressing today are my own, and may not comport with those of the Commission or any commissioner. For the past several years, we have seen a great resurgence in antitrust enforcement in the health care industry. A lot of what we've seen are challenges of physician organizations that are based on either a per se or quick look approach, meaning that the challenged conduct -- the allegations are to be condemned by looking at the restraints themselves rather than looking at their effects.

But in this forum and previous sets of these hearings and in other forums, the health plans have spoken at great length about the consolidation that we're seeing in physician markets. Health plans are arguing that in the face of this consolidation, they are compelled to contract with large physician organizations at prices that they would normally say are above market rates, and the reason that they feel compelled to do this is because employers, whose business they seek, demand a broad range of physician panels that cover all the areas where their employees live.

To date, neither the Department of Justice nor the FTC has challenged a physician consolidation in a

context where Section 7 of the Clayton Act would apply and we'd need to define product market, geographic market and calculate market concentration, but with a lot of these allegations out there and a number of issues before the agencies, it's likely that in the near future we will be faced with confronting some of these issues.

So, what I'd like to do this morning is point out some of the tools that are applicable to market definition and identify some of the difficulties that we may face in defining markets, some of the challenges, some of the issues that are unique to the physician marketplace.

So, beginning with the product market definition, the place that we would normally start is the horizontal merger guidelines, and the basic premise, of course, under these guidelines is that the appropriate product market is the smallest group of products or services for which a hypothetical monopolist could profitably sustain a small but significant nontransitory price increase. That's pretty basic, but it's still the right starting point.

Now, in applying this general standard to the context of physician services, we can first look at some advisory opinions and some suggestions in those

advisory opinions that both the Department of Justice and Federal Trade Commission have issued as to how this might be accomplished.

In virtually all of these situations, the assumption has been that each medical specialty constitutes a distinct and separate product market, but there's been one exception to this general rule, and that is in the case of what is commonly referred to as primary care physicians, because within this group of physicians that appear to compete with one another, we have doctors who define themselves as family practitioners, general practitioners and internists, but the precise contours of even this market are subject to some disagreement.

For example, in the FTC advisory opinion in Med South, the primary care physician market was said to include pediatricians. In some of the Department of Justice advisory opinions, pediatricians were excluded from the primary care physician market. It seems that the primary issue here in looking at and considering whether pediatricians ought to be included in the market is whether parents, as they select their preferences for doctors, view family practice doctors/ general practitioners or internists as substitutes for pediatricians, and also, from an economic and legal

point of view, the extent to which family practitioners, general practitioners and internists can target price increases to adults. Questions like that are going to depend on the facts of individual cases, so we may not end up with the same market definition in every instance.

Another interesting question involving the market for primary care physicians is the extent to which gynecologists may be included in that market. In some states, by a matter of state regulation, there is a right of access in a health plan for a woman to see a gynecologist. In some geographic areas, it's common for gynecologists to deal not just with health issues specific to women, but to really act as a primary care physician for women. So, depending on the facts in the individual marketplace, it may be appropriate to include gynecologists within the definition of primary care physicians.

A second kind of interesting issue which arises in product market definition is the extent to which integrated groups ought to be addressed, and the interest here is whether the individual physician is the actor in the marketplace or whether the market ought to be defined as a group of physicians seeking to serve a particular group of patients.

This arose in the Department of Justice advisory opinion involving Los Angeles Medical Group. That was a group of anesthesiologists, and in that context, the Antitrust Division concluded that because the groups contracted to provide a broad range of anesthesia services, including subspecialties, and that they competed against each other as groups, that the proper definition of the market was likely to be a group of anesthesiologists who are able to provide that full range of services.

We may have this question arise in even a more interesting context when we're talking about multispecialty groups, because in that context, there may be a question about whether the multispecialty group is really providing a different service than the doctors can provide individually. Do consumers have a demand for a service of physician services integrated across various specialties so that the patient could conceivably have a greater level of continuity of care from their primary care physician into various specialties? And I would suggest that a key question in evaluating this is whether the group is really providing a different service, or on the other hand, whether it's just providing the same service at a greater volume.

Now, turning to geographic market definition, we would again start with the general approach of the horizontal merger guidelines by asking what is the smallest area in which a hypothetical monopolist provider of physician services could profitably sustain a small, nontransitory price increase? We know from our experience in hospital mergers and just common sense that the market for physician services is going to be a local market. The statements of enforcement policy for the DOJ and FTC emphasize the local nature of physician markets, and the advisory opinions that both agencies have issued also state repeatedly that the markets are local.

But again here we have some interesting issues that are going to arise in applying the general principle to specific facts. There is a tendency in health care for us to rely strongly and heavily on patient origin data. That's proven to be in some cases a blessing and in other cases a curse, because in fact, patient origin data give us some objective standard by which to go and proceed, but on the other hand, there's a lot of difficulties in relying upon patient origin data, the foremost of which is the fact that it's merely a static analysis, where our analysis needs to be dynamic and needs to ask what would patients do in

the face of a hypothetical price increase.

The matter is further complicated by the difficulty of obtaining patient origin data for physician offices. We may be in a situation where we would substitute hospital patient origin data, and that would further remove us from the market we're trying to analyze.

Finally, patient origin data is problematic when it's used in large metro areas, because it tends to suggest that every large metro area constitutes a single geographic market. That tends to contradict evidence that employers, when they're selecting a health plan, seek to satisfy their employees by having physicians in the network which are close to where the employees live, and if you're looking at our larger metro areas and thinking about how that's going to play out, take the New York area, for example, you're not going to say that an employer in North Jersey is going to be satisfied with providing their employees with a physician provider panel that has lots of doctors in Southern Connecticut and Long Island. That's not going to bring satisfaction to the workplace, and one of the key things employers say over and over again is they don't want their health care plan to be a cause of employee discontent. So, we are going to face, very

much like in hospital matters, the difficulties in defining a geographic market based on patient origin data.

Finally, I want to just spend a moment considering the calculation of market concentration. The traditional approach found in a number of the advisory opinions and also found in a couple of privately litigated cases is that we just count numbers of doctors in a particular organization and calculate market share based on the percentage of doctors in a particular organization. That approach is sensible and seems to work well in the context of a situation where we have doctors that are exclusive to single organizations.

However, if we have doctors that participate in multiple IPAs and we calculate each IPA's market share based on its number of doctors, we're going to end up with some of our market shares being well over 100 percent. In that kind of market, it seems to me that market share is going to best be calculated by looking at the revenue of each physician organization and basing that particular organization's market share upon the revenue that is generated from the contracts that those organizations hold with individual health plans.

Thank you.

MR. BYE: Thanks, John.

I might ask the panelists and co-moderator to shift to the audience, because the next few panelists will be using Power Points.

MS. LEE: You mean sit over there?

MR. BYE: Yes.

MS. GUERIN-CALVERT: This is a short person's wonder to have a podium that moves down.

While we're waiting for it to come up, it's a great honor to be here, and what I would like to do is kind of follow up on what John had talked about and to really focus on some of the specific contexts in which product and geographic market definition comes up, the sets of issues that are being evaluated there, and then to talk about some practical ways in which, in addition to using patient origin data, that we could also look at ways in which to try to get a better handle on who are the actual participants in a relevant product and geographic market.

The context, first of all, obviously as John set out, is that what we are most concerned about is an effort to evaluate market power. We're doing that in many cases directly in the context of the physician markets, but as John alluded to, there are a number of circumstances in which what is going on in the

physician market may be relevant to analysis of other issues, such as HMO mergers, hospital mergers. So, I want to make in that context some specific comments on product and geographic market definition, but also to spend some time talking about empirical support, because I think as John mentioned, one of the tasks obviously is to understand the competitive effects analysis well, to not just be in a static world but in a dynamic world, and then as a result to really capture well and identify market participants trying to come up with good measures of share, but also then thinking obviously about entry and expansion, because I think in many physician market issues, whether or not there are prospects for expansion or entry of new physicians or new physician groups into the relevant area tends to be very important to everyone's conclusions with respect to the competitive effects analysis.

What I've tried to do here is to set out just some of the contexts in which physician market power and market definition issues have come up, both in terms of advisory letters, in terms of private action issues, as well as in terms of enforcement actions. One obvious one is in terms of physician network formation.

At the beginning of the health policy

statements, there were a number of issues where there were the first nationwide development of, say, cardiac groups that were going to be located in each of several metropolitan areas, able to do nationwide contracting with health plans, and there were some very important issues about market definition there, both locally, regionally and nationally.

And there have been a number of issues with respect to acquisitions and mergers of physician practices, both with respect to acquisitions by public entities, acquisitions by hospitals and then acquisitions or consolidations among physician groups in a particular marketplace.

With respect to hospital mergers, a very important mechanism that has been identified and discussed at great length in these hearings by which hospital pricing can be disciplined post-merger, is the ability of a health plan to have sufficient physician access or ability to be able to divert patients to other, arguably lower cost, hospitals. So, the availability in a given marketplace of sufficient independent hospitals who may or may not already have admitting privileges at other hospitals is an important part of how we evaluate hospital mergers.

Similarly, many of the HMO -- less so often

PPO -- but many of the HMO merger cases and vertical issues with respect to the effect of most favored nation clauses or other kinds of clauses have turned, in part, on the ability of a new entrant HMO to get access to a sufficient number of other physicians so as to be able to discipline the incumbent HMO. So, there -- and John alluded to that in terms of the exclusivity issues in terms of whether there are enough physicians left outside of a given panel to form a competitor panel.

In the private sector, there have been a number of cases which go to mergers and acquisitions but many of which have turned on exclusive contracting and physician admitting privileges or credentialing matters. These are very complex cases. Some of the exclusive contracting ones have tended to involve anesthesiologists, other kinds of practices which may tend to be more hospital-based practices, and again, one of the issues there is evaluation of market power and particularly the issue as to whether or not the hospital that may be engaging in the contracting has plausible alternatives either within the local market or, practically speaking, is able to attract another group outside the market. Some of the same issues are with respect to admitting privileges and credentialing.

I think -- and this is something that John alluded to -- is obviously market power definition is a demand-side analysis, and I think the most important thing, since we have so many different contexts in which it arises, is that we really need to be very specific about what's the nature of the claim. What is the concern that is raised about market power? Is it a concern that a group of physicians somehow have been able to raise and maintain prices for their services? Is it an evaluation of something that says that they are so large and have such an important skill set that there is not a sufficient set of alternatives that are available?

And I think we then get into having to define right away for the specific market definition exercise who are the customers that are purchasing the services that are affected. In some cases, it's much more specifically hospitals. As in the exclusive contracting case, it's a circumstance where a hospital may be making a choice to hire a group of anesthesiologists, neonatologists, emergency room physicians, a set of things, and they may be the immediate customers, obviously doing it on behalf of their patients.

There may be other contexts in which hospitals

may be having a concern that a particular group is so large in the area that they do not have the ability to have sufficient alternative physicians available to them to contract with. An example of this is that if you have a hospital system that may have its own HMO, where the issues come up is whether or not there are sufficient physicians other than those contracted to that particular hospital, particularly if it's a large one, that are available to the other hospitals in the area so as to discipline perhaps not just the HMO pricing and the physician pricing but also the hospital pricing. Obviously managed care plans in many dimensions, trying to set up panels, it's an issue.

And then lastly, in many cases we're looking at it at the outpatient level, looking to see what alternatives would patients have after a particular merger or a consolidation.

And just to touch on briefly something that John spent some time on, we have to look in each of those contexts as to what the relevant product attributes are, and again, to define preliminarily, and as John alluded to, the first area tends to be looking at it by specialty, and I think that this is something that one wants to be open-minded about in terms of testing to see, once you've identified your candidate

specialty, as to whether or not there are other physicians who can play particular roles that you may not have identified.

A specific area in which primary care versus specialists is very important is that particularly with respect to managed care plans, for many -- and this is increasingly less so -- but for many HMOs, obviously the primary care physicians are the gatekeepers, and so in terms of having access to a sufficient number of primary care physicians in order to be able then to go ahead and make referrals could be important in the evaluation of some market power issues.

Again, it may be at the individual physician level versus the group level, and something that I'd like to spend a little bit of time on as well, is that it's important in looking at group levels or the IPA level to identify what the concern is. For example, to give one concept, is that in evaluation of certain kinds of hospital cases and in certain kinds of managed care cases, issues have arisen as to whether or not there are sufficient independent IPAs that are available for contracting with a new plan or a plan that is concerned that it wants to switch patients away from a given IPA/hospital combination, and so obviously doing a head count and examining the relevant size and

the attributes of given IPAs is useful, but I think something that's important to keep in mind is that in many contexts, it may be possible for the managed care plan to do the assembly of the network itself.

So, if you focus too narrowly on the product market definition as the IPA, you may forget that an HMO may be able to assemble its own IPA which doesn't exist yet in the marketplace, but then you're needing to look at whether there are sufficient physician components that could be assembled to create an IPA. And obviously we blur -- as we do in many industries -- right away into a geographic component as well. There may be some needs not only to have particular specialties but a particular range of services for the particular customer.

I think with respect to geographic market definition, once you have the product market specified, you've identified the types of physicians that you are interested in looking at without any regard to geography, the types of groups that you're looking at, you're really saying for the group that you are or the set of physicians that you are concerned in a given area, that in that product market they have market power, you're immediately going to who are the effective alternatives. Who are the other physicians

or physician groups or entities to whom the affected customers could turn, again, not exclusively or completely but in sufficient numbers to discipline the pricing of the group or the set of entities that you're concerned having market power? Not everybody has to switch, just enough to discipline. So, obviously we come down to trying to identify those market participants.

In my experience, I think there are some practical tools that are readily available and increasingly available even at the screening stage fortunately on the internet to be able to at least do plausible head counts and plausible sets of information, starting with you have certain kinds of physician databases, you have medical society lists, you often times have IPA membership lists, and you have HMO websites.

Let me kind of talk about the managed care databases, because this is one that I have found to be most productive to use. If, for example, you're evaluating -- let me just pick a state randomly -- if you're looking at Missouri and you have a particular concern that has been raised that a specific group of physicians in a given county have market power, let's say they're primary care physicians, and there's the

concern that they have the ability to raise and maintain their prices directly to patients, to managed care plans, and that that is an issue. How do you test whether or not there are effective alternatives for those physicians?

One of the places you can go is if you identify first of all what are the panels that those physicians are on? You can identify in many cases relatively quickly the three or four top HMO or PPO panels that they're on. Typically what you can do now is you can go onto that HMO's website, whether it's, for example, Blue Cross or Aetna or United or some other entity, and you have the ability very quickly to click on their HMO product and to pull up for a given county usually -- sometimes it asks you for zip codes. The ones that are the best are the ones that let you do it by county and even by state, but it will immediately give you a list of all of the physicians.

It often times gives you their specialty, may give you their secondary or tertiary specialty. So, they may be an internist who's also board certified in infectious disease. They often times will give you each of the physician's office locations, including zip code, city and county. It may give you some additional information. Some of them will give you the hospitals

at which that physician has admitting privileges, and sometimes it will also give you, if relevant, the IPA that they belong to.

You can also get onto an IPA's website and find all their member physicians. They're usually classified by primary care and specialist.

So, what you can build from this -- and of course, it's the case that the names are never quite the same in each of the databases, and some of them do require you to input every single zip code separately, but you can without enormous difficulty get a sense of for the given county and say the surrounding four or five counties what does the population of physicians by type of specialty look like, and you can then begin to put this particular group in context.

In addition, what you can do is -- again, depending on the nature of the case, to the extent you're examining something that has a particular concern about whether or not the group of physicians constitutes a very, very large share of a particular hospital or group of hospitals' admissions and as a result there is a concern that there are not sufficient other hospital -- not sufficient other physicians to whom that hospital or other hospitals could turn, you could look at a hospital privilege list, and as John

alluded to, this is one of those elements that's pretty static. It gives you name, address, specialty, gives you some idea of who's relevant but no sense of the order of magnitude.

So, what you may want to go to -- and again, this is usually available from the hospitals -- is you can get by physician the number of discharges that they have, by DRG, zip code, what plans that those discharges were under, which IPA those physicians may belong to, and again, you may be able, depending on the case, to evaluate overlap in discharge patterns. So, you can readily test then the hypothesis of is it the case already that this group of hypothetical physicians in a given Missouri county, are they really accounting for a substantial share of a given hospital's discharges, or indeed, might there be substantial alternatives already in place, and then one can look at expansion.

To go back up to the managed care databases for a moment and to talk about a point John addressed, one of the things I have found very possible to do working with physician groups and also with hospitals is it is possible to get a sense and identify from where are the physician groups at a given location attracting their patients, and what I have found is that in metropolitan

areas such as Manhattan, Washington, D.C., San Francisco, it is the case that a very substantial number of residents of the suburbs do, indeed, have their primary care physician in the immediate downtown area, because they tend to use physicians and go to physicians' appointments when they are working there, and -- but that is something that ought to be tested.

It's an empirically verifiable set of information that one can look at to identify at least as a baseline, is it the case or is it not that there are substantial inflows of patients from the areas for standard services such as family practice, general practice, gynecology and other kinds of services.

Something also that's important to take into account is in general, the narrower the specialty, the fewer the number of physicians there may be, the greater the concern. Perhaps it is also the case the less frequent somebody is going to see a cardiologist or a cardiac surgeon or a neurologist or a neural ophthalmologist, and so as a result, the more it is that people may be willing to travel, the more it is that reputation may matter and affiliation with hospital may matter. And again, if you look at the physician's draw pattern, historically the broader the actual draw pattern of his or her practice may be.

I think to try to make it more dynamic, as John suggests you really want to make it a dynamic analysis, we should really be looking at what are the practices that the physicians are doing? Are they increasingly, in order to attract volumes, doing marketing efforts, setting up satellite offices in suburban areas to draw people in more so? And again, to look at the actual patterns. But I have found that the patient data is very useful for looking at what actually has gone on.

Since my time's up, let me just kind of go very quickly to in terms of looking at share, I think it's very important, the most important thing is to look at whether or not you are looking at nonexclusive groups versus exclusive groups, because many times the same physicians are in multiple panels, and so you have to take that into account in evaluating whether or not you have a concern.

I think by far the most important thing -- and again, to take it from being static to making sure it's dynamic -- is to look at what the practical experience in the marketplace has been with respect to expansion. Many markets are very dynamic, with expansion of locations, expansion by entry of new physicians, tendency toward nonexclusivity and reaching out in broader areas and bringing in new physicians by

hospitals. That makes, in general, for broader markets, less of an issue.

So, in general, where I would conclude is saying market power could be a substantial concern, but I think there's a substantial amount of data that are available to us fortunately to be able to test in a particular context whether the concern that has been raised is something that's real or whether there are substantial facts that one could point to to say we don't need to be quite so concerned.

Thanks.

MR. BYE: Thanks, Meg.

David, would you like to give the next presentation?

MR. ARGUE: My name is David Argue. I'm with Economists Incorporated. I'd like to start first by thanking the FTC and DOJ for allowing me to come, inviting me to address some of the issues in physician product market definition.

Just by way of a summary of where I'm going to go, I wanted to comment a little bit on the merger guidelines and the appropriateness, as John pointed out, of using the merger guidelines for market definition purposes. I have a few comments on product market and the delineation of markets by specialty.

There are some distinctions in geographic market that I think are important, we ought to mention a little bit.

We talked a little bit about the primary care versus specialty care distinction, but there's also something underlying that hasn't been addressed head on, which I think is important and has some very important antitrust implications of the office-based versus the hospital-based physicians.

And finally, take a few minutes to talk over some of the challenges and information sources. As Meg indicated in her talk, there are some good sources, but there are a number of shortcomings.

Just beginning with some thoughts on the merger guidelines, and I agree wholeheartedly with John that conceptually the right place to start is with the merger guidelines, the hypothetical monopolist paradigm of an attempted price increase, and then consideration of whether there would be sufficient payer and patient switching to defeat that price increase, and an integral part of that is a critical loss analysis or something equivalent, so that you're measuring whether you've met that sufficiency threshold.

One of the aspects of a standard merger guidelines analysis that's likely to be especially relevant for physician market definition is the

possibility of price discrimination. Antitrust issues in physician matters are most likely to arise in situations where it's a large group to begin with. To the extent that these groups have different locations, for example, and are able to price differently in the different locations, it may result in effective price discrimination that would require an analysis of separate markets. And I will talk a little bit more about that in a few minutes.

With regard to product market definition, the fundamental challenge for physician services is the same as it is in a lot of other health care services, and that is that from a patient's perspective, the individual service that they're receiving isn't interchangeable, you know, isn't interchangeable from a medical standpoint, and consequently, the patient often can't switch services based on price. Even though that fundamental principle seems to exist in a lot of health care analyses, very seldom are product markets defined based on those.

Rather, they are defined based on the specialty of the physician. Some of that's convenience; some of it's just a practical matter of doing it. There are occasions where there are exceptions or ad hoc distinctions that are made, but they're often made as a

matter of convenience rather than a rigorous application of the model.

If, for example, specialty physicians are treated as a group, it's unlikely that each of those specialties constitutes, you know, an equal ability for patients to switch among them, but nevertheless, they may be treated as a group.

One product market that often does have physician specialties grouped together is, as John indicated, primary care services, and typically primary care services are thought of to include internal medicine and family medicine, often pediatrics and sometimes OB/GYN or at least the GYN component of it, and the rationale is that many of these physicians or these physicians provide many of the same services so that a patient can decide which one of those specialists they want to go to.

Obviously that's not true for all of them. You wouldn't get a pediatrician providing adult medical care, but nevertheless, there are some services that are interchangeable among them which tends to lead to those being grouped together into a single product market.

In contrast, specialty physicians are typically considered to be in separate product markets by the

specialty. There may be some circumstances where particular services overlap. A neurosurgeon and an orthopod might both be capable of doing spinal surgery, and whether that's relevant or not to an analysis depends on the particular issues at hand.

An important distinction in product and geographic market definitions for physician services is that between office-based physicians and hospital-based physicians. The office-based are primary care doctors, general surgeons, a number of medical specialties, as distinct from the hospital-based physicians, which might include the anesthesiologists, the neonatologists, ER doctors, radiologists and an assortment of others.

What are the distinctions of office-based physicians? Well, typically an office-based physician will treat patients in their office, certainly see them in their offices, although they would use hospital services with some frequency depending on the nature of the specialty. They usually have privileges at hospitals, but they're seldom employed by or contracted by hospitals.

There was a period a number of years back where a lot of hospitals acquired primary care practices. There's still some of that around, although a lot of

that has gone by the wayside. More typically, the office-based physicians are not employed by hospitals, and the office-based physicians compete directly for patients. They get onto managed care contracts and are getting their patients directly rather than through the hospitals.

The hospital-based physicians, in contrast, are contracted typically or employed by the hospital, sometimes on an exclusive basis. So, a single anesthesia group or a single neonatology group may be serving the hospital. And often it's the case that those physicians are there to serve the patients that come in through the hospital. Those physicians aren't necessarily themselves out attracting the patients. They're there receiving the patients as they come through.

Some of these types of physicians, radiologists, for example, may have both hospital-based practices and office-based practices, and while that distinction is relevant for an analysis if you focus on just the hospital part or just the office-based part, you get back into that split of the types of physicians.

Importantly for an antitrust analysis, as Meg alluded to, the hospital-based physicians are distinct

from the office-based physicians in that they compete for each other to be providers for the hospital, to get that contract or to become employed by the hospital, and that carries a critical element to assessing what the antitrust implications are going to be for a hospital-based physician analysis as opposed to an office-based.

Turning to the issue of geographic market, John had indicated -- and I think he used the term "common sense" -- would suggest that physician markets tend to be local, and indeed, that premise is often accepted. Whether it's true or not is a factual question, and it's not a bad place to start, but ultimately it needs to be tested.

The geographic market for office-based physicians may, indeed, be local, but even in that category of office-based physicians, there's likely to be some variation. Primary care physicians could have smaller service areas. Specialty physicians might have larger service areas if the managed care plans are willing to incentivise patients to travel greater distances, and I guess in conjunction with that, if the patients themselves are willing to travel farther distances for those specialty services. Again, the validity of those suppositions is factual in nature,

and it depends on the particular analysis being conducted.

One of the important distinctions that's missed in this presumption about patient travel patterns is that distinction between hospital-based and office-based physicians. The hospital-based physicians compete for contracts to be employed by or contracted by hospitals. Consequently, their markets are not likely to be local. They serve patients on a local basis, but they compete for those contracts nationwide or at least on a regional basis.

The hospitals have incentives to attract physicians or to employ and contract physicians who will provide the desired service at a competitive price, and the hospitals frequently exercise their ability to terminate contracts or fail to renew contracts and hire a more desirable group.

Typically, there are no particular barriers to entry to these types of hospital-based physicians, and part of the reason for that, anyway, is that, as I mentioned, hospital-based physicians serve the patients who are coming through the hospital. They don't have the same referral issues that office-based physicians might have, and they don't rely on the same patient-physician relationships that many office-based

physicians would have.

And finally, turning back to price discrimination issues, as I indicated, there may be large groups that have multilocation practices scattered throughout some area of consideration, and to the extent that they can price differently in those different locations, issues of separate geographic markets arise, and potentially issues of unilateral effects from a merger would arise as well.

Now, having said that, since I qualified just about everything I said with a "may" and saying everything is a factual analysis, it probably warrants a little bit of time on what sorts of information can you use to address some of these questions of market definition. There's certainly information that can be applied to product market definition. I'm going to focus mostly on geographic market.

As John had said, one of the sources of information is just what are the employers saying? There are interviews and documents that may be relevant for that. And as Meg had indicated as well, there's information out there of different quality and different reasonableness to acquire on physician locations. But what I wanted to focus a little bit more on was what about the patients themselves? What

can we find out about the patients?

Before I get to that, let me just cover this or tie off this hospital-based physicians aspect. In assessing the extent to which there are -- the size of the market for hospital-based physicians, it's typical that the hospitals will have recruiting information, there are placement services that you can find information from as well, and certainly so-called trade press advertisements.

But what about this patient-flow information? One of the sources -- and office-based physicians often have it -- are the practices themselves. They may have their own patient records -- they will have their own patient records; whether they're usable or not is another story -- and that information in a large group can often be good, computerized, easily accessed, easily worked with, but in many physician practices, it's spotty, it's of questionable quality, and there's only a limited amount of work you can do with it.

Another source is referral information. Sometimes it's useful to find where a specialist is receiving his referrals from, how many referrals are coming from this doctor in that town or this doctor in the other town.

Probably the best source of information for patient-flow is the utilization data from insurance companies, and it's a proxy for patient origin data because it includes competing physicians. It's not just the group you're working with but all the other groups in the area that are contracted with that managed care plan. The data tend to be much better quality and much more comprehensive. Of course, there's always the proprietary issue of this, that you can't always get your hands on it.

And finally, there are some other public sources of information that are analogous to the hospital information that's typically available through the state agencies but maybe a little bit different. Sometimes there's ambulatory surgery information that's out there that will identify the doctor performing the surgery. And the same thing with hospital inpatient data, in some states they'll identify the doctor. You can then track it back as to what that doctor's specialty is and get a record of where that doctor is receiving his patients from, at least as far as the inpatient goes or at least as far as the ambulatory surgery goes. There may also be specialized data sources, although that's a lot less frequent.

So, one question that comes up is, well, what

do you do if you don't have complete data? And I know there are a lot of different approaches to this, and I'm just going to discuss one of them that I think may be helpful. Suppose you're representing a group and all you've got is your own physician data. You can get from public sources where the locations of the competing physicians are. Then, one approach you might take is to find the service area for your doctors, use that as a proxy for the service area of the other doctors, and check for the overlap of services.

Now, if my slides work, I'll see if we can walk through one of these. Let's see, this is some semi-fictitious data for the physicians that we might be representing or interested in, in this case they are identified here as these purple stars -- they're kind of light purple, a little hard to see -- but clinic one, two, three, four and five, and the symbols are the their patients, where they get their patients from, where they're located.

So, the first step is to find out the service area, say a 90 percent service area, whatever seems appropriate for your clinics. In this case, this is just one clinic, clinic number three I guess. It's toward the center of that. Then identify that service area, approximate it with something. Here I've drawn a

circle on there. Maybe you're going to use a different shape, maybe just use the outline of the zip codes or what have you.

The next step is to identify the competitors, competitor A, B, these blue crosses, C, D and so forth, and follow that up with superimposing that service area over your competitors. You don't know where the competitors actually get their patients from, but we're approximating it using our own data. Then you can see that a lot of your own patients are actually located in the service area of some other doctor.

That's far from perfect, but given the lack of data, this may be some way to get a sense as to whether there's competition for or alternatives available for your patients.

Just concluding, let me recap a little bit. I want to go back and stress that the merger guidelines is a good place to start. The common problem in health care, they're often difficult to implement, but at least it gives you the right guideposts and the right concepts to go through, including remembering this price discrimination issue.

The distinction between office-based and hospital-based physicians is not just something to gloss over. It can have some real important antitrust

significance in terms of what the geographic markets are and the extent to which there are competitive issues.

And finally, no matter what you do, you're going to run into some challenges in the data issues, and it's just a matter of applying what you can or what you've got to the issues that are ahead of you.

Thanks very much.

MR. BYE: Thanks, David.

Monica, would you like to make the next presentation?

We'll just have a brief break and start back in a couple of minutes.

We'll cancel that break and start right up. Thanks for your patience.

MS. NOETHER: All right, with that great intro, now that you've seen all the email from everybody, I assure you my presentation won't be nearly as interesting.

One of the advantages and disadvantages of being the third economist to talk is I can get through some of the stuff, many of the things that I have to say on product and geographic market, are things that David and Meg have already touched on. I was relieved to see that I had done some stuff a little bit on

physician fees, which is something they haven't talked about, so maybe I'll try to get to that a little more quickly, although there the evidence is very mixed as to what one can do.

Obviously physician competition has been a hot issue in the last several months, as there has been more and more scrutiny of physician practices, and it comes at a time when, in fact, there hasn't been a lot of empirical work that at least has been published on physician market definition, and some of that is due to the -- well, a lot of it I think is probably due to the paucity of data that are available, and so we're all kind of struggling with how to get a handle on it better.

So, as I say, I will talk about some of the things one can do with the fee data when one can get it, imperfect as they are, but first let me add my own observations on product and geographic market. As has been suggested already, one of the issues to think about in product market definition is the extent to which specialties compete, and as David pointed out, in fact, from the patient perspective, which is one of the perspectives one certainly wants to think about in market definition, they're really thinking about particular services that they need to consume, and so

for certain particular services, different specialties may compete, whereas they don't for others.

Family practice sometimes competes with obstetricians in the delivering of babies. Similarly, they sometimes compete with pediatricians in treating the sick kid or the well kid. And sometimes, I don't have it on here, they actually compete with internal medicine physicians in the treatment of adult patients. Internal medicine, though, often also classified as a primary care specialty, I think is less likely to try to compete with obstetricians and pediatricians than family practice, and that's just sort of the training and the way physicians think about it.

Neurosurgeons and orthopedic surgeons certainly are recognized as different specialties. They have on the supply side different kinds of training, different kinds of board certification, but on the demand side do provide some of the same services, some of the same surgeries, such as the spine surgery that David mentioned. So, therefore, at least in some circumstances may be viewed as competitors by patients.

And the other relevant thing to take into account here are referring physicians. When you get to the surgical specialties, most patients usually end up in the office of a specialist through a referral from

their primary care physician. So, the views of the primary care physicians and how they select which specialty to refer to can have an impact on market definition.

Now, just another example, interventional radiology and cardiology, they sometime also compete for cardiac angiograms.

Questions to ask in thinking about to what extent different specialties do compete, is it an urban or a rural geographic area? And this is where you get the mixing in of product and geographic market considerations, as Meg mentioned. In urban areas where there's a dense population and a big referral base, I think physicians tend to be more specialized. So, you can go to the subspecialist, not just the orthopedic surgeon, but the orthopedic surgeon who does nothing but spine surgery or the orthopedic surgeon who does nothing but hand surgery, whereas in a rural area where there's a much lower referral base, there are less likely to be specialists and particularly not subspecialists, so there may be more overlap, broader range of services provided by different specialties.

To the extent that there are different specialties, they may substitute more for each other. Primary care physicians may do more in rural areas than

they do in urban areas. So that I think in thinking about which types of physicians compete with each other from a product perspective, it is important to think about the geography that's involved as well. Because of this, I think the population in rural areas is more likely to be tolerant of generalist physicians or they travel more.

Also, I think there are often significant differences across the country in practice patterns. Certain areas of the country, because of the nature of medical school training and just custom, historically may just do things a different way, so there's been a lot of analysis of local practice variation done by Jack Wenberg up at Dartmouth that looks at numbers of different services provided in different areas of the country and just huge variation that cannot be explained by differences in health care characteristics of the population. Some of that also translates into local physician practice patterns and referral patterns as well.

Kinds of evidence to look at in figuring out the extent to which different specialties compete with each other, to the extent that you can get views of managed care or just even look at the construction of their physician panels, do they have a full range of

specialties, or if they are trying to cover a less densely populated area, do they lack the subspecialists, which suggests maybe that there's more substitution of general physicians.

What are the referral patterns of the local physician community? Are they referring always to a particular kind of specialty, or do they sometimes refer their patients to one specialty and sometimes to another for the same condition? What kinds of requirements do hospitals have about board certification in particular specialties? What kinds of subspecialties are they trying to attract to their medical staff? That can give you information as well.

And finally, obviously, if you can get it, looking at fee data can be instructive, though I do want to caution you that just seeing that there are differences in the levels of fees that physicians in different specialties charge for the same services is not necessarily indicative if they don't compete. It could be that there's some kind of equilibrium differential, and if you want to be a subspecialty that would raise its price, you still would see shifting, but you're starting out with different levels. So, if you're doing an analysis with fee data, to assess this question, you really want to look at changes over time

and try to get to some measure of cross-elasticity, which, of course, is usually impossible given the data available.

Just to bring home the notion of some variation in fees, what I have here are data from a single large multispecialty group practice that has a number of offices in an urban area, and what I'm showing here are the fees for two particular kind of office visits, one a mid-level visit for a new patient and the other a mid-level visit for an established patient. So, these are fairly precisely defined, specific CPT codes that physicians use to bill, and what I'm showing are the fees that are -- now, I will say these are charges, and that's another issue. Just as with hospital data, charges are often the only data you can get. They obviously are not the same as transactions prices and can be more or less meaningful depending on whether the actual payment rates are calculated as a percentage off the charges or something different. But at any rate, we see here that even the charges do vary somewhat across the different specialties for these office visits.

Now, in some cases these are not specialties that are going to compete, but on the other hand, it's possible that, in fact, the pediatrician charging $145

for a new visit, a new patient visit, is, in fact, to some extent competing with the internal medicine person charging $130 but doing perhaps a slightly more thorough job.

Another issue that comes up in product market definition is: To what extent are physicians and associate allied health professions complements or substitutes? I think physicians would often like to make the associated allied health professions complements to them. Obviously that way they would have less competition from these allied health professions, but also they can extend their own productivity and run a more efficient practice if they can find a way to use the allied health professions as complements.

Various examples of allied health professions who might complement or substitute for an associated physician specialty, a well known one, anesthesiologists and certified registered nurse anesthetists, and there has been some litigation on issues related to this, relating to whether nurse anesthetists can get privileges at hospitals to practice independently. Obstetricians and midwives in delivering kids; ophthalmologists and optometrists, at least for certain services, sometimes compete, but also

sometimes will work together, where the optometrist provides the post-surgical care and the ophthalmologists provide the surgery.

Orthopedic surgeons and chiropractors are probably more generally viewed as substitutes than complements but in certain situations might work together. And finally, primary care physicians and nurse practitioners. In some areas of the country, nurse practitioners will practice independently, and in others they essentially assist physicians and, again, may be more productive.

Kinds of things to think about, about whether one should think about the allied health professionals as providing any sort of competition to particular physician specialties, regulatory restrictions on the scope of allied health professions, scope of practice vary substantially across states.

In some states, for example, optometrists can prescribe medications, eye medications, and in others they can't. That obviously limits the extent to which they can compete with ophthalmologists. The same is true of other allied health professionals.

Supervision requirements, I think there is variation in the extent to which midwives can operate without any supervision from obstetricians or when they

need to refer to obstetricians. The same with CRAs and anesthesiologists.

As I said before, this kind of analysis has to be done on a service-specific basis. There may be some services where the allied health professionals, in fact, do compete and substitute for the relevant physician specialty and others where they complement them.

Other kinds of evidence that one might want to look at, practice patterns. Do you see collaborative relationships between the physicians and the allied health professionals that suggest complementarity? I mentioned the co-management of eye surgery patients. Again, that's something where there is substantial variation across the country, areas where ophthalmologists don't want to have anything to do with optometrists and other areas where they recognize that they can, in fact, augment their own practice and they can, in fact, see more patients more productively by employing optometrists. The same with CNAs and anesthesiologists.

Nurse practitioners have been certainly thought of as -- particularly in rural areas -- a substitute for primary care physicians, yet it seems that the data suggest otherwise. A recent study by MAMSI's National

Ambulatory Medical Care Survey, which is actually a very large database of physician office patterns, shows that 96 percent of office visits, the patient sees a physician at least part of the time. So, this suggests that nurse practitioners are not completely substituting for physicians in any kind of major way.

On the other hand, attempts by allied health professionals to obtain hospital privileges certainly suggests that they view themselves as able to substitute for specialists in certain areas at least. Again, the kinds of evidence that one might want to look at are very similar to the previous question on to what extent do specialists compete? What do managed care plans do in setting up their panels? Is there any evidence that one can get of price competition?

Turning quickly to geographic market definition, I want to sort of differentiate a little slightly different dimensions than the previous speaker has, though some of the same issues arise, and that is to distinguish between the short run and the long run, where I define the short run essentially as where the existing supply of physicians in an area is fixed, and there are obviously varying views of how long this short run lasts depending on how easy one thinks it is to recruit physicians to a particular area.

In this situation, from the patient perspective, the extent of the market is largely going to depend on the patient's willingness to travel, and as has been mentioned before, patients are often more willing to travel further for tertiary services, as is the case with hospital care as well, and I think in general rural patients either accept a broader product market by going to generalists rather than specialists or they accept a broader geographic market, i.e., they're more willing to travel.

Physician willingness to travel, I think, is also something that should be taken into account. Are physicians willing to at least travel to admit to multiple hospitals in a broad urban area, or do they want to focus their patients on a single hospital? This, again, I think tends to vary by specialty. The subspecialists tend to be more likely to practice at multiple hospitals, because they need the combination of different referral bases to get a sufficient volume of patients.

Again, the other I think dimension where physician willingness to travel is relevant is in some of the other kinds of markets that physicians operate in. We've been focusing on the market for patient care, but, in fact, there are other services that

physicians provide. For example, they need to be medical directors to various kinds of different clinics, such as a dialysis clinic needs to have a medical director, so if one is thinking about competition to become the medical director of a dialysis clinic, the relevant question has nothing to do with patient travel patterns, but rather, where can you get the physicians who are going to provide that medical direction service, and that's going to then, in turn, depend on how far physicians are willing to travel.

Unfortunately, there are few data that exist to test these propositions. I think David and Meg have covered some of the data that are available or all of the data that are available on the patient side. There isn't really much on the physician travel patterns, except looking maybe at where they have privileges relative to where they have their offices, to the extent that you can get that information.

In the longer run geographic market, the question is whether physicians are willing to move to a particular geographic area if physicians' incomes start to rise in that area due to anticompetitive behavior. There is systematic physician income variation across the country that has existed for many, many years. I

think it's pretty well known that physician incomes on either coast, either the Atlantic or the Pacific coast, are substantially lower than they are in the rest of the country, so obviously income is not the only thing that affects physician location decisions, and there is, in fact, a body of research that tries to tease out the different factors that do affect physician location.

A recent study in the Journal of Health Economics suggested, not surprisingly, that physicians who don't have a loyal patient base are more likely to be willing to move, so the hospital-based physicians are certainly more willing to relocate because they don't depend on establishing a patient referral base, and similarly, younger physicians who haven't really built up their practices are also more mobile.

But at any rate, there is, I think, an implication also from the income disparity that there are certain areas of the country that are just more attractive to physicians, and all else constant, it's more likely probably to recruit into those areas than it is into a rural area in some central state. Also, generally, I think urban areas, because of the population density and the more or the greater assurance of a patient base, find it easier to attract

physicians than rural areas. So, again, not something that one can analyze very rigorously, but things to take into account.

Finally, let me talk a little bit before I talk more about the fees just about entry a little bit, and I think this is an area where in the long run, at least, the market clearly does work. Just an example that I happen to be personally familiar with from work that I've done is anesthesiology. About eight years ago there was a headline in the Wall Street Journal on the front page, "Numb and Number: Once a Hot Specialty, Anesthesiology Cools as Insurers Scale Back."

That's a story that describes the experience of several anesthesiologists newly out of residency who were either working five different jobs to pay off their medical school loans or were driving taxicabs because they couldn't get jobs, and it essentially attributed the then-current job shortage of anesthesiologists to managed care that was denying surgical procedures and essentially reducing demand for anesthesiology, and also this article projected that there would be a further decline as CRNAs gradually took over more and more of the role of anesthesiologists, because they were cheaper.

That prediction came out of a study that had been commissioned by the American Society of Anesthesiologists that I actually undertook, which essentially forecast future demand for anesthesiology services and what the "need" for anesthesiologists would be based on how much CRNAs were substituted.

So, what happened as a result -- I don't know whether it happened as a result of this article but sort of as a result of the fact that new anesthesiology trainees were having a really hard time getting jobs -- was the word got out, and there was a substantial decline in the number of anesthesiologists entering residency programs.

So, what has happened now is, if you read the trade press, anesthesiologists are in very hot demand. It's very hard to recruit them. So, if anything, there is excess demand for anesthesiologists. And in fact, if you look at what's happened to anesthesiologists' incomes relative to all other specialties, you can see that, in fact, not surprisingly, that period in the early nineties, anesthesiology incomes were high relative to other specialties. This probably reflects the fact that it had been in short supply.

Lots of physicians entered residency. Presumably if you extended the line back to the late

eighties, it would also be high up there, and as they came out of medical school or out of residency in the early nineties and flooded the market, surprise, surprise, anesthesiology incomes went down, and now we see them going back up. If you looked at the 2002 numbers, they'd be high again, suggesting in the long run, in terms of thinking about specialties, that the physician population or the potential physician population does certainly respond to these things.

Similarly, I don't know if you've been following the trade press that apparently cardiac surgery, which used to be a really hot specialty, now can't even fill their residency slots because so much cardiac surgery is now being done noninvasively and also because cardiology surgery reimbursement has gone way down.

Turning, as promised, a little bit to some of the things that one can do with physician fee data, obviously if one had, you know, really good physician fee data that showed transactions prices and was really disaggregate, then you could look directly at the direct effects of alleged anticompetitive behavior. You wouldn't even have to worry that much about the precise market definition, because you could estimate cross-elasticities of demand and you could look at

whether prices had gone up.

Obviously we are not in that kind of a world, which is why we're mainly talking about market definition, but there are some fee data out there, and sometimes you can get a hold of things, and so there are some things to think about in terms of if you are lucky enough to get some fee data, what kinds of things you should think about in working with them.

One obvious question is standardization. Physicians bill using at least 7000 different -- they are called CPT codes that all indicate different services, so trying to do any kind of analysis on 7000 separate fees -- it would be less than that for a single specialty, but still could be several hundred -- tends to make the analysis pretty cumbersome.

You can do and what is often done is standardizing by something called relative value units, which are essentially the units that come off of the Medicare physician fee schedule, which the Medicare physician fee schedule is known as RBRVS or the Resource-Based Relative Value Scale, they are at least intended to reflect variation in the resource available from physicians. That's the problem associated with providing different services. It's only a supply-based

measure.

It doesn't reflect differences in demand, but at least it is a way of standardizing fees to some extent, so you can take the fee for a particular service, divide it by its relative value, and you could get a more standard measure, namely, the dollars per relative value unit.

Another issue that you need to think about is that many particular individual codes may have multiple fees associated with them, for example, radiology procedures. If it's just the physician providing the service, that physician bills a professional service fee. If, on the other hand, the physician owns the equipment and is providing the service in his or her office, he or she will bill a global fee that incorporates the capital costs of the equipment.

You can't distinguish between those two. There's no way to interpret the fee data that you have. So, you have to make sure that you know whether you're looking at professional or global fees.

Finally, many surgical services have modifiers attached to the fees, indicating whether it's a surgery that's done with another procedure or whether it's a surgery that's extra complicated. So, again, these are things that if you're going to analyze fee data, you

need to keep in mind.

Where you get the data tends to be from claims data, from managed care plans, or maybe from a particular physician group. Looking at claims data, you have many of the same issues that you have if you're trying to look at claims data on the hospital side. The data are, while voluminous, not necessarily particularly easy to interpret. Often, despite their voluminousness, they don't have the information you need.

You may not have information on specialty, for example. You may not have information on all of these modifiers that I was talking about. Physicians now do tend to all have unique identifiers that were established a number of years ago by the Government, so it is easier now to figure out a particular physician's claims than it used to be, but often, if you've got a bunch of physicians practicing in the same group and operating under the same fee schedule, you can't link them together. So, that's another problem.

And finally, there are a lot of adjustments -- I shouldn't say finally, but in terms of just my laundry list of issues, adjustments to initial claims. If some payment gets reversed or challenged or whatever, it may be difficult to link with the initial

claim. So, you don't know that the fee you're looking at is actually the fee that was actually finally paid.

But given all those --

MR. BYE: Could you wrap up, please?

MS. NOETHER: Sure, I will wrap up quickly.

Given all those caveats, different sources of physician fee data, the best place tends to be from managed care plans who actually have good transaction data, and if you get those kinds of data, you can ask questions about whether a particular specialty or group has raised price substantially in a short period of time. That's the sort of temporal question that you can get from a time series of managed care data.

Or, if you're trying to look at a particular area and it's a managed care plan that operates in multiple areas, you can compare physician payments across different areas.

Benchmarks that may exist to make comparisons, the Medicare RBRVS is out there, but not particularly very useful given that it tends to be, as I said, just a resource-based measure and therefore not reflective of different demand conditions or different competitive conditions in different markets.

There is a database out there called Medicode that Ingenix puts out that gives you percentiles of

charges. The advantage it has, while it is just charges, is that it is available at a very detailed level, specifically for any zip code or CPT code combination.

Let me just close with what is going to undoubtedly be a very confusing picture, but this is essentially taking that same physician group that I showed you a slide for before and comparing their fees by range of CPT code that respond basically to specialty and comparing it to these Medicode data, and what we've got here are median charges per relative value unit. So, I have done that standardization that I mentioned, and what you can see is that it's really very hard to draw any conclusion in this case about specialty in that some of the fees are higher for the group than they are for the so-called market standard. This is for Medicode -- at the CPT code level at this particular urban area where this particular physician group operates.

The other thing that is interesting is to look at the variability. The blue lines essentially show you the ratio of the 95th percentile of fees to the median fee, the upper line, and the lower blue line shows you the ratio of the 75th percentile to the 50th percentile of charge per RVU by specialty category.

So, you can see that even within this urban area, there is a fairly large variation in the fees, making it that much more difficult to draw any kind of firm conclusions.

So, on that pessimistic note, I will close.

MR. BYE: Thanks, Monica.

We might actually have a quick break now, so if you could return in five minutes, that would be great.

(A brief recess was taken.)

MR. BYE: If everyone could take their seats, we will start back.

Howard Feller will give the next presentation.

MR. FELLER: Good morning. I want to thank the FTC and Department of Justice for having me here today. I'm going to talk about a number of the topics that are covered in the list for today. Can everybody hear okay in the back?

I'm going to first talk -- try to be brief -- about the definition of the product and service market, and then I'm going to talk about the relationship between physicians and health care plans, and lastly, the extent to which physician concentration and integration affects the amount paid by health care plans to physicians.

Now, first, with regard to the definition

issues, the legal standards -- and I am going to talk about it from a lawyer's perspective since I am not an economist -- but the legal standards that govern the definition of the relevant product and geographic market are fairly well established, and for the service market, which is really what we're talking about here today, you focus on the services that are reasonably interchangeable for the same purpose, so you look for physician practice areas that can substitute for other practice areas.

For the geographic market definition, you try to define the area of effective competition where the physicians practice and where patients can turn for alternative sources of supply. The geographic market issue has been litigated frequently in hospital staff privileges cases, and in many of those cases, the plaintiff physicians have tried to define the relevant geographic market as the hospital at which they have been denied privileges or lost their right to practice.

However, virtually every court that has addressed this issue has held that the relevant geographic market is not limited to the hospital at which the plaintiff physician practices; rather, using the traditional analysis, the courts have defined the relevant geographic market to be the territory within

which the physicians sell and provide their services and where the patients can practicably -- which is an important concept -- find alternative physician suppliers.

Now, while these legal standards obviously are important to set the analytical framework, from a practical litigation perspective, the facts are what drive the determination of the relevant product and geographic market. This issue is very fact-specific and is really won or lost based upon the facts that are presented, and the quantity and the quality of the facts presented are very important to this analysis. As a result, a detailed factual analysis is critical to determine what the proper service and geographic markets are in a case.

Now, starting with the service market, I agree with some of the comments that have been made here today, that the specialist labels should not be controlling and a more realistic assessment of alternatives needs to be evaluated. For example, let's take radiology, and some of that's been touched on today. Radiology has historically been viewed as a separate specialty area for physicians, but today, many different types of physicians, such as cardiologists, general surgeons, orthopedic surgeons, rheumatologists,

neurologists, oncologists, many others, read and interpret x-rays on a regular basis. Many of them have x-ray machines in their own offices.

To determine whether radiology constitutes a separate service market or whether these other kinds of physicians need to be brought into the definition of the market, you need to look at the extent to which these services really are interchangeable. They may be interchangeable for some uses but may not be for others. And part of this analysis may require an evaluation of the quality of the x-ray interpretations that are being performed by that physician and by radiologists in comparison. For certain kinds of procedures, a higher quality and a more specialized type of interpretation is needed than others.

Now, turning to the geographic market, as a practical matter, the geographic market definition depends on an evaluation of a number of factors, and you've heard a lot of these ticked off today. Patient origin data, which usually focuses on zip codes from where the patients reside; physician referral practices, such as where primary care physicians refer for speciality or specialized services; the location of physician offices; the hospitals at which physicians have privileges; the views of managed care plans as to

the areas that are included in a geographic market; and the marketing activities of physicians in an area, such as where they advertise their services.

Now, this analysis of where patients are likely to turn for alternative physician services often boils down to a mix of distance, convenience and the type of service needed. So, a mix of distance, convenience and the type of service needed. People are likely to travel farther for higher level specialized services. For example, some people who need cardiac surgery or a heart transplant are likely to travel to facilities that are located several hours away in order to get the desired level of care.

As a result, in analyzing the geographic market for higher level specialized services, like cardiac surgery, it's instructive to look not only where the patients of those specialists in the area come from, but also look at other comparable specialists who do other kinds of procedures to see where they get their patients from. This will shed some light on whether physicians in different geographic areas actually compete with each other or not.

I'd like to make a comment about the traditional type of economic analysis that's used in defining the geographic market. Traditionally, the

geographic market definition has relied primarily on a zip code analysis, and you've seen examples of that today, of where the subject physician's patients come from. They look at the zip codes of where that physician's or where that type of physician's patients come from.

Now, you saw from the presentations made by Meg, Dave and Monica today that they look at other factors. Now, these are all very good economists, but I would submit to you that there are some economists out there who focus very heavily on just a zip code analysis. This zip code analysis, however, only presents a static and limited view and a partial view of the relevant geographic market.

A number of other factors need to be analyzed to determine where patients could practicably go for alternative physicians, the legal test requires, even if a high percentage of patients in an area currently use physicians in that area. I agree with John's earlier comment that patient origin data is limited and should only be part of the analysis, and I would suggest to you that a good example of a more detailed geographic market analysis is contained in the Eighth Circuit's 1994 decision in the Morgan Stern versus Wilson case. That's found at 29 F.3d 1291.

In that case, the plaintiff cardiac surgeon practiced in Lincoln, Nebraska, and he alleged that the relevant geographic market for cardiac surgery services was limited to the city of Lincoln and its surrounding areas. The plaintiff relied on an economic analysis, an economic expert report, which showed that the large majority of residents in the Lincoln area went to Lincoln cardiac surgeons.

However, the Court went beyond that zip code analysis and found that the geographic market for cardiac surgery services included not just Lincoln, but also Omaha, Nebraska, which was located 58 miles away, and the Court did that because consumers in Lincoln could practicably turn to cardiac surgeons in Omaha for services. And in fact, when they talked to primary care physicians, they found that primary care physicians viewed cardiac surgeons in Omaha as reasonable and viable substitutes.

Now, that's all I'm going to say about market definitions, since I think it was pretty well covered today, and I want to turn to the main thing I want to talk about, which is the relationship between health care plans and physicians and particularly the market conditions and trends that are affecting their rate negotiations.

To do that, we first have to look at how physician reimbursement normally is set. Health care plans, as I'm sure you know, compete with each other in a number of areas, such as price, which in that case is the premium rate to groups, quality, service, benefit packages and provider networks. The last area, provider networks, is very important to health care plans, because they need to develop adequate networks of physicians and hospitals to provide access and covered services to their members.

To put these networks together, health care plans typically enter into provider agreements with physicians that are of relatively short duration, and these provider agreements include fee schedules that the health care plans offer to the physicians who are willing to participate in the plan's network. The fee schedules set forth the specific amounts that the health care plan is willing to pay the physicians for the services they perform by CPT code.

Most health care plans set their fee schedules by monitoring a number of things. They look at the participation rates of the physicians in various practice areas and specialties. They try to obtain as much information as possible from physicians about the fee schedules offered by other health care plans. And

they estimate their total physician payment cost based upon projected utilization of services. So, a health care plan usually has an annual budget or cost budget that it needs to meet, and it will try to set its fee schedules for the various physician practice areas and specialties within the constraints of that budget.

As an example, let's say that a health care plan budgets a 2 percent overall cost increase for payments to physicians in 2004. Its fee schedule will literally have a list of dozens of different physician practice areas and specialties that are in that network, but not all of those practice areas and specialties are going to get that 2 percent increase that's projected for 2004.

Instead, the health care plan will prepare a fee schedule which lists each physician practice area in its network and will come up with a proposed fee increase by group, you know, for that area in 2004. Some practice areas will receive an increase that's more than 2 percent; some will be kept flat; and others, in fact, will probably see a decrease in their payment levels from the health care plans.

Now, health care plans typically make these decisions as to who gets what on that schedule, which practice areas get an increase, who's kept flat and who

gets a decrease, they typically make that based upon a supply and demand analysis. The health care plan assesses supply and demand by, again, focusing on the participation rates of the physicians in their network. If a health care plan has a high participation rate in a physician practice area, it most likely will conclude that its payments for that practice area are adequate, and it will not increase the fees for that practice area in 2004.

On the other hand, if a health care plan does not have an adequate number of physicians in a practice area in its network, it will probably decide to increase its fee schedule for that practice area in order to attract and persuade more physicians to join its network. So, for example, if a health care plan doesn't have enough urologists in its network, it just hasn't been able to sign up enough urologists, it's probably in the next year going to look at raising its payment rate to urologists to try to get more people in the network. So, this is essentially how the fee-setting process works between health plans and physicians in many markets, and I might add, it's also a perfectly legitimate way of setting physician reimbursement under the antitrust laws.

Most health care plans then, based on that fee

schedule, offer a standard amount set forth in their fee schedule to physicians in the geographic market or area covered by that fee schedule unless other factors come into play, and now I'd like to address some of those other factors.

There are a number of market conditions and trends that are directly impacting the relationship between health care plans and physicians, especially the amounts paid to physicians, and I would suggest bear watching by the FTC and the Department of Justice. These trends include a high level of concentration in certain physician practice areas; increased affiliations of physician groups through partial integration or the use of common consultants or the use of practice management firms; and the acquisition of physician practices by hospitals. I'm going to take these separately.

First, in many areas of the country, especially in the smaller cities and the rural areas, there is a growing amount of concentration in specific physician specialties. Some of this has occurred as a result of natural growth by practice groups, and some of this has occurred through mergers and acquisitions over the years. Since physician practice group mergers and acquisitions are typically very small deals, they never

hit the Government's radar screen and are usually not scrutinized from an antitrust standpoint.

However, what we are now seeing is that there is a high degree of concentration in some physician practice areas in many communities throughout the country. Now, typically this is not going to be the case in Washington, D.C. or New York or Chicago, but it is going to be the case in many smaller cities and rural areas throughout the country.

Now, these physician practice groups that tend to be large in these communities usually hire business managers, and they have become much more aggressive in their dealings and negotiations with health care plans. In fact, some large practice groups, which have a substantial share of a particular practice area, have been using their market power to raise the rates that are paid by health care plans and obtain a higher than normal rate increase.

In situations where a physician practice group has a very high share of the market, very often the tables have been turned, and these groups have more leverage in the negotiating process than the health care plans. Because the health care plans need these large physician practice groups in order to maintain an adequate network of providers for their members, they

often feel a need to agree to the higher fee demands of the large physician groups.

As a result, there is evidence from many places in the country which indicates that physician concentration has had a direct impact on the rates paid by health care plans for physician services. And since many of these situations occur, as I indicated, in the smaller secondary cities and in rural areas, they often do not receive the same amount of attention that market conditions in the larger cities attract.

However, I would submit that this increased amount of concentration in physician specialties is an area that bears watching by the federal agencies as they continue to monitor competition in the health care market.

Secondly, I would submit that there also has been increased pressure to raise physician reimbursement because of a recent trend of physician groups to either partially integrate or affiliate their practices with others, and this has been happening in a number of different ways, and I'm talking about situations that are outside of the cases where physician groups or organizations try to financially integrate their network or may not do it successfully, but they at least are trying to fit the models.

As most of you know, there are many consultants and health care attorneys, but usually not antitrust attorneys, who are trying to sell physicians and physician groups on the advantage of partially integrating or partially coordinating their practices, but I would submit to you that in many of these situations, these consultants either do not understand or do not follow very carefully the FTC/DOJ policy statements on physician network joint ventures.

In a number of markets, consultants have convinced previously independent physician practices that they have adequately combined and integrated their practices if they use the same tax ID number to submit claims for payments; if they jointly hire employees; if they utilize the same staff for billing and collections; and if they jointly advertise their practices.

However, if you look beyond and look behind those arrangements, you see that many of these practice groups have not attempted to financially integrate, because each group remains a separate profit center, and no group is dependent upon the financial performance of any other group. These physician groups then attempt to negotiate jointly through their consultants or their health care attorneys with health

care plans under the umbrella of the so-called coordinated activities, and they use their larger size to try to obtain higher rate payments from health care plans.

Another variation of this is the use of a common practice management firm by a number of physician groups in the same specialty and in the same geographic market, so this is where a number of physician practice groups that are in the same specialty kind of area, practice area, all hire the same practice management firm to do their business work for them, manage their practice. What happens here in many cases is that the practice management firm gets each physician group, when contract renewal time comes up with a health care plan, to request the same rate increase from the health care plan, and if the health care plan refuses to give the same rate increase to the various practice groups, it faces the prospect of losing contracts with either all or most of the physician practice groups in a specialty in that geographic area, and therefore, will not have an adequate number of physicians to fill out its network. This practice has also put pressure on health care plans to raise physician reimbursement.

And lastly, a number of significant hospitals

or hospital systems throughout the country have attempted to improve and expand their market position by acquiring large numbers of primary care and specialty physician practices. Now, I hear from Astrid this does not occur in California and a few other states in the country because of some statutory bars that they have, but in many areas of the country, there is no such statutory bar, and many hospitals have, in fact, acquired sizeable numbers of primary care and specialty practice groups.

Health care plans often are at a disadvantage in dealing with these large hospitals because they need the hospitals and they need their own physicians in order to have a competitive network. So, these hospitals in some of these cases have aggressively used their market strength to obtain higher than normal or higher than competitive level, I would submit, rate increases for their own physicians.

This trend towards building large hospital systems with a sizeable amount of owned physicians should also be watched carefully and monitored because of its possible anticompetitive effects.

The FTC and the Department of Justice, I'll just close by saying that they have for many years been looking at the activities of physician network joint

ventures, and most recently, we've seen the fruits of some of that in terms of actions that have been brought against networks that claim to be messenger models but really were not. I would suggest that the agencies expand their focus to monitor these other trends of increasing physician concentration, the other forms of integration or affiliation, such as common practice management firms that are being utilized by physician practices and hospital acquisition of physician practices.

Thank you.

MR. BYE: Thanks, Howard.

Our final presentation will be from Astrid Meghrigian.

MS. MEGHRIGIAN: Well, I'm going to get personal very quickly here. Being the last panelist, I'm both scared and embarrassed. I must confess, I'm not nearly the expert in the antitrust laws as my predecessors are, but one thing that I can promise you is that I am a compassionate advocate for the ability of physicians to provide the optimal level of care to their patients in what a difficult environment we do have.

At the outset, I want everyone to appreciate, I work for the California Medical Association, and this

is not a monolithic group of people by any chance. It's actually got in more conflicts than some of the other people and its law firms that are here. In fact, we represent small physicians and group physicians and owners of groups and reports from owners of groups that, in fact, they are getting faced with extra highly competitive pricing fees from reimbursements and reports from specialists that they're getting excluded from groups and generalists and specialists and self-proclaimed monopolists because they're the best, urban physicians, rural, suburban physicians and physicians from LA. So, what we have is a whole interconnected mess of physicians that oftentimes have adverse interests against other physicians.

So, when I was looking at what I was going to say today, I was saying, oh, my God, you know, whose side am I going to be on? And I actually decided to be on the side of what's best for patient welfare.

In California, at least, I don't know what numbers you're looking at, there is a severe underfunding of health care in California. There's been a crisis in the state as many of you may have heard. Many physicians and physician groups have gone bankrupt, closed their doors, restricted their practices, and it's been disastrous for everybody.

Physician-patient relationships are destroyed. There has been disruptions in care, which does result in negative patient outcomes. And for patients, in addition to the disruptions, there's just longer waiting times and access problems in general.

In light of all of what's happening, I think that what makes the most sense at this point is to have a broad common sense application of the antitrust laws and that the use of narrow definitions of product and geographic markets and mechanical and statistic approaches really makes little sense in today's environment.

First, with product market, I think that we all learned this morning that the general issue is substitutability, and substitutability, I think, is an objective factor that is based on whether there were others who can do the job, not how well they can do it. CMA has been very concerned about the use of reputation, you know, in terms of when they're dividing markets, when markets are analyzed in terms of whether or not a specific group has a good reputation or not.

First, reputation is not a factor which is to be used for substitutability. The issue is what alternatives are available to the consumer and can they get the care elsewhere? Substitutability does not turn

on whether those existing alternatives have the same or identical reputation. And in fact, you can never do that when you're talking about human beings. No two persons have the same or identical reputation. It's an impossible task.

For that reason, reputational factors for the purposes of product definition really contradicts the Clayton Act, which recognizes that a labor of the human being is not a commodity or an article of commerce. Therefore, medical services should not be treated as commerce.

California case law, by the way, recognizes this and says because of the dependent nature and the trusting relationship between the physician and the patient, you never want to treat physician services as a commodity in trade, which brings us to the next point, and that is reputation as a practical matter in terms of the way businesses are structured and financed and sold can never be bought and sold. So, let's look at it in the context of distinguishing it from good will.

Good will is an asset that can be bought and sold, and in fact, as we learned from the Office of the Inspector General, if it's bought and sold beyond the fair market value, there are actually fraud and abuse

implications, but in both the commercial and medical contexts, good will can be sold and is tradable because of consumer ignorance. That is, because of what people did in the past, consumers are willing to go to this place not knowing if the people who have purchased the asset are as good as the people in the past. There's consumer ignorance.

Reputation, on the other hand, is a product of an individual whose reputation rises and falls with the reputation of that individual. It cannot be sold separate and independent from that individual. So, to treat reputation as an asset, as a practical matter -- and that's allow one class of physicians to be distinguished from another -- demeans the very concept that the labor of these individuals cannot be treated as an article of commerce, which the Clayton Act says we can't.

Next, reputation is, in our opinion, antithetical to the very purposes of the antitrust laws, which are to encourage people to get a good reputation. And in fact, by using a reputational analysis, it, in fact, punishes physicians for being the best. You know, this issue was sort of discussed in the Blue Shield/Blue Cross versus Marshfield Clinic decision where the HMO argued that because the

reputation of the clinic was superb, it was really a monopoly, and therefore, you know, there needed to be some sort of challenge against the clinic.

Well, the Court there rejected that, saying that the suggestion that the price of being best is to be brought under the authority of the aegis of the antitrust laws and stripped of power to decide whom to do business with does not identify an interest that the antitrust laws protect. The successful competitor, having been urged to compete, must not be turned upon when he wins.

Next, we are concerned that reputational analysis actually assists competitors and not competition and in and of itself creates some sort of barrier to entry. The big reputational case in California was the ORLA case, which was the one that was earlier mentioned, which involved a group of anesthesiologists, and their reputation was a factor in dividing the market, because there was some testimony that was gotten from some of the surgeons in terms of who they thought would be the best and who they would be willing to work with.

I don't know the facts of that market at the particular time, but I do know what's happening now at least in California, and there are two things going on.

Number one, we have gone to the OIG on this, there is a number of instances of coercive contracting in California, where hospitals are coercing physicians to enter into certain managed care plans at certain fee levels as a condition of contracting, and at the same time there's instances of terminations and exclusions of physicians who advocate for quality of care.

In California, the courts have created an affirmative obligation of physicians to protest on behalf of their patients, and as a result of this protesting, they're considered by some to be rabble rousers, and they have been either terminated or excluded from the positions of medical staffs, health plans, medical groups, et cetera. CMA actually sponsored legislation to prohibit that retaliation, but unfortunately California courts are a little confused sometimes, and the application of that statute has been heavily litigated.

But I guess my point in this context, that hospitals and physicians have a say in arbitrarily deciding who has or has not a good reputation, there may be even more coercion to satisfy managed care's contracting needs of a hospital. Physician advocates may be wrongfully excluded from the equation, and there could be further barriers to entry to the extent

remaining groups are labeled as having an inferior reputation.

Next, reputation, as we all know, is subjective criteria, and it's subjective criteria that we believe is inappropriate when defining inherently complicated matters such as medicine. I mean, when you're dealing with a patient, you're dealing with severity of illness, comorbidity, heredity, outcomes and pain thresholds. Now, when you're looking at all of this, how can you tell who is good and who is not? Professionals still can't do that.

I mean, despite an enormous amount of resources and money and experts that have studied the issue, there's still no reliable mechanism that exists which fully risk-adjusts physician outcomes data. And you know, many consumers are very knowledgeable and able to tell who are and who are not good physicians, but still, many consumers still don't have an idea in terms of who is a good clinical physician, because a lot of that depends upon, again, outcomes, pain thresholds, diagnosis, and a lot of it depends upon bedside manner.

As a result, and because the issue of product market really depends upon substitutability, courts don't like this type of testimony and tend to reject it to the extent it does not address what alternatives

remain.

Having said that subjective factors should not play a part in product definitions, when it comes to geographic market definitions, we think it should be a common sense application, particularly for small markets. We think that the courts and the agency statements do recognize the need for special exceptions for small markets and that it really makes little sense to require, you know, at least individual physicians in rural areas to compete with each other, because there's some real efficiencies and consumer benefits that could be obtained through allowing them to join their practices, and that's where we hope that the agencies will also look at creating an exception or a safe harbor similar to the small hospital merger safe harbor that's in the safety zones.

Finally, in terms of the overall issue of barriers to entry, we do think that the barrier to entry is not a physician-created one but it is due to a lack of underfunding and the high concentration of plans, at least in California, where 5 percent of the plans hold about 90 percent of the market, and we hope that the agencies will direct their attention to the monopsony power of the plans.

Thank you.

MS. LEE: Thank you.

I want to thank all the panelists for their informative presentations, and we're now going to begin our question and answer session. I'd first like to begin by inviting the panelists to ask questions of each other or to respond to other panelists' presentations.

I'm going to start with Meg, who I know has some questions that she would like to ask.

MS. GUERIN-CALVERT: I wanted to pose one overall question to any of the panelists, because I think that there are some potentially different views on the usefulness of patient-flow data here than I've heard before in the context of hospital patient-flow, and just to maybe set up the question, it strikes me that what Howard had set out was the concept that patient-flow data on the physician side may be too static and may be best as a starting point or a baseline and that you really needed to look beyond it, but that it is a useful starting point.

I have heard elsewhere -- and I don't know whether John was referring to it in this way -- of a concept of where patient-flow data may be static and may be less useful because it's historic and that the fact that you are looking at the fact that perhaps a

very large number of patients may, indeed, for example, move from the suburbs into the center city may not be predictive of whether or not others would also move and others would have alternatives.

So, I would just raise for the group, where do they think patient-flow data works? Is it something that really encompasses useful information with respect to what has actually happened with referral patterns, admitting patterns, use patterns, managed care use patterns, or is it something that one should not use at least as a baseline?

MR. ARGUE: I'll start, just give a thought or two on that, Meg.

I think that the patient-flow data -- first of all, it is difficult to get, and that alone may limit its usefulness, but to the extent that you can get real patient-flow information so that you can see people from a certain area using various alternatives, it's analogous to what we would do in a hospital case, and yes, it's got limitations because of the points that were raised before. It's static, it's not a perfect reflection of where people can go, and the application, as I think that you've done in the past and I know that I have, is to apply some sensitivity tests to that, some assumptions as to the likelihood of people being

able to move, just to get a sense as to what other alternatives might be available should there be a price increase.

I don't know that that's fundamentally different than the way that patient origin analysis is currently used, but again, it's only one part, and I don't think anyone would disagree that there are other elements of an analysis of markets that's going to be relevant in addressing that.

MS. NOETHER: I guess I would agree that it certainly provides a starting point, and it I think can be useful if you don't really understand a market particularly well and don't understand the relationship, say, between the suburbs and the inner city areas. It's a good way to at least see the way patients have been behaving in the past if we could get the information, but certainly it should be something that is taken in the broader context of looking at other things, like the views of managed care and the views of referring physicians and the views of hospitals, the more qualitative information that I think, you know, gets more towards the dynamic nature of the market.

In terms of the historic nature of patient-flow data itself, the extent to which that really is a

limitation is in part dependent on what question you're asking. If you're looking at the effects of something that's going to happen in the future, like a merger, then clearly relying on historic data is limited. If you're trying to assess whether something bad has already happened, if you've got enough historic information to see whether there have been any changes in patient-flow, that can help you assess the activity and also the extent of the market. So, I think it is in some circumstances, but in no situation is just looking at patient data, patient-flow data, sufficient.

MS. LEE: But haven't the courts relied on patient-flow data a lot in terms of defining geographic market? I mean, there seems to be a consensus, at least amongst the economists, that it gives you a snapshot in time and certainly will not tell you what would happen in the face of an anticompetitive price increase.

MS. GUERIN-CALVERT: I would differ with that a little bit in the sense that I think -- I would agree certainly with the part that particularly in the hospital context, but also in the physician context, courts have systematically looked at and used patient-flow data as an objective source of information that can be tested.

Where I would disagree is that I think what a lot of courts have done is to go the next step and really push either the plaintiff or the defendant to address the issue as to how might that data, those data, inform whether or not in the event of a price increase there actually would be a substantial supply response, a substantial switching to alternatives.

An example of a case I'm familiar with in California, there was an inquiry as to whether or not it would be the case that in the event of a hypothetical price increase, you could demonstrate that there would be sufficient use of other hospitals so as to discipline pricing, and looking at both where patients are currently going and in what numbers, what order of magnitude, and then as David alluded to, looking at and examining the critical loss, how many more would have to move to make a difference?

That's something, interestingly enough, that courts seem very comfortable with in trying to get a handle on how much more and is there enough evidence. They do look at other factors to try to show that that's going to happen, but I think they do use it as the basis for doing a dynamic analysis.

MR. FELLER: Yeah, I would agree with Meg that courts do look at the patient origin, patient-flow

data, pretty heavily in either a hospital-type case or a physician case, but they really do, at least many courts, want to go beyond that and look at the other kinds of qualitative evidence. Often what you're presented with in a piece of litigation are sort of dueling patient origin data studies, and you have, you know, differences as to what is the number, you know, that you should look at and how you define that, and the courts get faced with those kinds of things, and they do look for evidence of referral patterns by physicians, where do managed care plans view -- what do they view the market to be, and if there was a need for a change, what would they do in response, and so a lot of that comes into play, because you often are faced with two different reports that are somewhat different in terms of the statistical analysis.

MR. WIEGAND: In looking at the question that Meg poses, how many more patients would go in a certain direction, if there's already, say, some going from suburb to central city for medical care, physician care, the question may be answered perhaps by looking at what the employers say, because in a way, they're the purchasers of the services.

If we look at employers that are in the suburbs already, they may say, the folks that are in the

historical data that are going to the city, those are folks who are working in the city, and the health plans that are being purchased for them have adequate provider panels in the city, and they're willing to take advantage of that, but for those of us who are maintaining our offices out in the outer suburbs, our employees aren't willing to do that. So, we may need to look kind of behind the data to employers to see how many more patients are willing to travel in a certain direction.

MS. LEE: Let me switch gears a little bit.

There's been a lot of discussion about the definition of physician markets on the selling side, but what has not come up is the definition of physician services on the buying side. So, one question that I thought of a little bit, and I'd like to get the panelists' input on, is can we think of physician services for HMOs and physician services for PPOs as being two separate product markets, or, you know, do we think of this also as physician markets for managed care versus, you know, physician services for indemnity plans?

MS. GUERIN-CALVERT: If by that you mean if the HMO is the purchaser on behalf of all of its enrollees and on behalf of all of its employers?

MS. LEE: Actually, I mean something a little bit different from that, which is that a -- you know, the flip side of looking at a selling side issue is, well, could a hypothetical monopsonist impose a, you know, small but significant nontransitory decrease in price, for example, so is it that -- you know, what I've heard from different physicians is that, you know, some prefer dealing with just PPOs, for example, that HMOs impose a lot more administrative burden, and they're not equipped to deal with that. So, it seems that rather than switching to an HMO, which may, in fact, you know, reimburse at comparable rates or perhaps slightly higher rates, they prefer to just sell their services to PPOs or are more willing to contract with PPOs.

On the flip side is that, you know, some physicians prefer selling -- you know, prefer dealing with HMOs. They're set up to deal with that and they like that sort of situation.

MS. NOETHER: When you think about a monopsony question generally, you need to think about from the physician's perspective all of the sources of revenue that physician can get. So, limiting it to narrow insurance products like HMO or PPO doesn't seem particularly realistic.

That being said, if it were the case that it was truly such a hassle to get payment from an HMO, then one could perhaps argue that that source of revenue needs to be excluded from an equation, but that doesn't seem like that's consistent with most of the facts that one generally encounters.

MR. FELLER: Yeah, I think you're actually asking a different question. I don't think this is a definition of a physician market. I think you're asking a question of how you would define the purchaser market in that case, and is it HMO versus PPO or traditional indemnity or something else?

In my view, health care plans offer a variety of products, insurance products, whether it's traditional indemnity, PPO, HMO, POS, there is all kinds of varieties today, and typically the providers are signing up with a multitude of different products. So, you know, it's difficult to say that you have distinct product markets within that insurance segment, and employers are offering usually a menu of different products for their employees, and they get a choice of whether they want to go with the HMO option or they want to go with the PPO option or some hybrid.

So, I think that's the question that you're asking, really how you define the purchaser market as

opposed to the physician market, and I guess my view is it's difficult to define in many cases a separate -- carve out a separate HMO market, for example, and exclude the PPOs and the traditional indemnity and all that, because they do compete with each other.

MS. GUERIN-CALVERT: I would agree with Howard. I think in part what you would be looking at is attempting a factual circumstance, to say, first of all, you have in a given area, a given market, so few managed care plans who are providing all of the HMO and PPO products, and I would agree completely with Howard, you have to look at and see if there's any basis whatsoever for concluding that an HMO is in a separate market from a PPO.

I think there have been some claims and some issues raised as to whether or not certain managed care plans may be requiring that if you want to be in the PPO, you also have to be in the HMO, or certain kinds of things that can raise some more complications there, but I would agree, you fundamentally have to look at is there a sufficient alternative, and then in general it is the case that reimbursement levels for HMOs have tended to be substantially lower than for PPOs.

In part, there is supposed to be a sense that HMOs are more restrictive panels, so as a result,

someone is likely to get more volume of business. There have been some issues as to I think whether that, indeed, has been the case as well.

MS. LEE: Let me -- I think I did ask the question the way I meant to. You know, I started thinking about this in the context you mentioned, Meg, which is, you know, there have been some issues about insurance companies requiring physicians, you know, to sign up with, you know, their different plans, and physicians, you know, in some areas have quite a strong reaction to this, and one thing that, you know, some of these physicians would say is that, you know, I'm just not equipped to deal with that HMO. So, the fact that different types of -- it seemed like, you know, that these could be thought of as different products, that a hypothetical PPO monopolist could impose that price decrease -- a price decrease and, in fact, that physician would not switch away to selling to HMO service -- to selling, you know, medical services or physician services to HMOs.

I understand that this is a factual inquiry, and you know, as Monica noted, it's pretty rare now to meet a physician that doesn't contract with HMOs. There are some that exist, but you know, that is part of the factual inquiry.

John?

MR. WIEGAND: There is one structural -- I notice -- I don't know how prevalent it is, but that is the increased frequency with which HMOs are willing to negotiate fee-for-service contracts with individual physicians rather than with IPAs, so the situation where the physician says, you know, I'm not willing to handle this, the health plan says, okay, we will not delegate to you utilization management, quality assurance and, you know, other kinds of things that we would normally delegate administratively, we would normally delegate to an IPA in an HMO contract, but instead, we will just put you on our HMO provider panel, we will retain those administrative functions ourselves, and we will pay you on a fee-for-service basis.

We are seeing that more at least in California. I just don't know how prevalent that's become, but that kind of structural response is what we're seeing to physicians who say I don't want to take that HMO product line.

MR. ARGUE: I think if I could just add something in response to the question, and it seems to me that there may be an aspect of it that's really not an antitrust issue, that if an HMO is imposing

additional costs on physicians in terms of their participation, and then you would expect a PPO would be able to reimburse physicians at a lower rate and not lose physicians going over to the HMO panels, regardless of whether there's any competition issue in that. So, it's just a matter of a physician trying to decide where are they better off, incurring some of these administrative costs or taking a lower reimbursement.

MS. LEE: I want to give Matthew an opportunity to ask some of his questions as well.

MR. BYE: I would be interested to hear other panelists' views on the distinction that David talked about, which is the office and hospital-based physicians and how that would affect the product market definition.

MS. NOETHER: Well, I think it's certainly true that the hospital-based physicians are not so much competing for patient business but more are competing for a contract with a hospital. That's most starkly the case when you've got a hospital that has exclusive contracts with particular groups of physicians, so you have groups of physicians -- the only sort of dimension then is competition to become the exclusive provider at the particular hospital, but I think there

are a lot of other situations where it's more mixed, where you might have multiple groups of anesthesiologists practicing at a hospital, and in that case, then, there may still not be direct competition for the patients, so in that sense, it's different from PCPs.

On the other hand, they're still going to be competing for referrals from physicians or at least working with physicians, and that is analogous to at least the role of office-based specialist physicians. So, I think it's a continuum.

I wouldn't, I guess, draw the same totally stark contrast, but I think there certainly are different issues and different types of competition of more or less importance, depending on whether it's a PCP, an office-based specialist or a hospital-based physician.

MR. WIEGAND: The structure of the market, too, for hospital-based physicians I think, as David suggested, makes entry barriers much less of an issue, because you can enter into a market for a hospital-based physician with basically a full load of patients if you win the contract to serve the hospital. So, entry barriers may not be as significant for these, and I think it's an important point in the analysis.

MS. GUERIN-CALVERT: I think also the point that David had referred to in terms of the scope of the geographic market is very important here in the sense that while the services are delivered locally, the ability of the hospital to reach out and replace what typically may be a smaller number of people from outside the particular geographic region is one where there's been a lot of study done that looks at groupings of people and the ability of hospitals to attract people into the marketplace.

I think the other part is that it's important in terms of identifying what is clearly an additional mechanism that's available to discipline pricing. To the extent that there is a concern about the prices that may be charged by such a set of physicians, it's important to look at whether or not the hospital incentives are actually to try to exercise some discipline on that so as to improve their circumstances relative to other hospitals in an area, and that's something that is a little bit less relevant, obviously, in terms of looking at office-based physicians.

The one other area where hospital-based is important to the analysis of physician markets generally as well is that some hospitals have chosen to

use hospitalist programs, and in some cases, not in all, that has set up a circumstance whereby physicians in office-based practice are more willing to have admitting privileges at a broader set of hospitals, because they know that there's a core group of physicians at the hospital who can do some of the basic management, and so that's been a change that, again, depending on the specific marketplace can make a given set of physicians locally sustain more competition than what might otherwise be the case.

MR. BYE: Those comments lead on to two other questions I'd be interested in hearing views on. One is entry barriers. At a geographic level, we have had some different views expressed, and also over a physician's career, do they change?

MR. ARGUE: I think just a quick comment on entry barriers, setting aside the hospital-based physicians, and I think I expressed before that as the hospital is trying to attract physicians to that position to fill their ER or to fill their radiology department, they can search nationwide. There's really no reason why another physician group couldn't come in. But this notion of barriers to entry in physician services has to keep in mind that it's not just getting doctors coming out of medical school and, you know, the

entry isn't you go to medical school, you do your residency, and you know, this multiyear process of getting into the business, but from a competitive standpoint, it's are you able to switch from location A to location B in response to a price increase or not, you know, that would allow you to get in, and I think that for individual physicians, that's often straightforward to do.

There are issues that need to be confronted with regard to establishing referrals, whether you need a large group in order to enter or multiple providers to enter. There are occasions where an individual physician can enter and then recruit others to go along, you know, it doesn't have to -- the scale issue, you know, how significant a scale does this entry have to occur at. I think these are all important. The answer to that is going to depend on the type of specialty, the location that they're in and so forth. So, fundamentally, it comes back to a factual question again.

MR. FELLER: Another factor I think that I would add to what Dave had to say is when you look at sort of potentially the geographic area you're dealing with, say, for example, you have a one-hospital town or you have a two-hospital town and they have exclusive

contracts for the type of service that's at issue. You know, you may have some entry problems in those kinds of communities where there's a limited number of hospitals and they have exclusive contracts, let's say, for anesthesiology services. That can also be a barrier to entry as well.

MS. GUERIN-CALVERT: I think also in terms of looking at local communities, one of the things that I have seen working on a number of different matters is that there is more entry than one would expect in the sense that if you look at hospital admitting patterns over time, you do see changes, where people retire, and you do see new physicians showing up and becoming significant admitters, and again it goes to the incentive of a hospital working with a local community to try to ensure that obstetricians and gynecologists are, indeed, moving to town as the one or two obstetricians may choose to cut back on their practice or to retire, and so there's an alignment of interests there.

Another mechanism that I have seen work very effectively is moderate-size groups in smaller communities, but even in metropolitan areas, are very actively trying to attract younger physicians who may already be in practice who can more quickly become part

of established referral practices and eventually take over. So, the concept of having to go into a solo practice into a small community is less the mechanism by which things are occurring and that there is actually in many communities a fairly surprising rate of entry by new physicians, particularly if they are viewing that they will ultimately take over a somewhat small practice. It's an empirical issue, but I think there are mechanisms in place in many communities for it to occur and evidence that it has occurred.

MS. NOETHER: Yes, I think the major issue for the prospective physician thinking about entering a market is how easy is it going to be to be able to build up the patient base, which usually depends on referrals of some sort, so entry by joining an existing practice, as Meg mentions, I think is often a fairly low-cost mechanism.

However, if you've got a competitive problem in a town where there's only one big group, say it's a small town, then coming in as that solo practitioner to try to compete may seem like a more difficult issue. So, once again, I think, you know, as everybody has said, one has to examine the dynamics of the particular market in question.

MR. BYE: Do we need to factor in the

nonfinancial aspects that physicians take into account when deciding where to move?

MS. NOETHER: It certainly seems to be the case that entry into urban areas where there tend to be medical schools, a lot of physicians tend to practice within, you know, not too huge a distance from where they've gone to residency, or just areas that have the nonpecuniary benefits that physicians tend to like I think probably have an easier time of attracting physicians than the typical areas that are for good reason called underserved.

MS. GUERIN-CALVERT: I think it's also a trade-off, as Monica had noted in her information, the East Coast and the West Coast, in part because of heavy managed care penetration and, in fact, in part because of very large metropolitan areas, have very, very substantial volumes of physicians in almost every specialty and relatively low rates of reimbursement for a lot of specialties as well, and as a result, substantially lower incomes.

And so I think as with all professions, it's a trade-off between looking for the quality of life nature of an area but also looking for a relatively long-term, secure income, and while there may be a lot of attractiveness to staying in Washington, D.C. if

that's where you did your residency, it may be that a moderate-sized town in Missouri or a, you know, a larger city in Kansas may give you much greater long-run opportunities, you know, in terms of your affiliation with a hospital and so on than you could ever hope to get in a given metropolitan area, and I think that's where the dynamics are showing substantial shifts of physicians into areas, but I would agree with Monica, smaller, rural areas continue to have the problems they have always had with attracting sufficient physicians.

MS. LEE: So, it's always true that economists find it easier to disprove a proposition than prove one.

MR. ARGUE: Absolutely.

MS. LEE: And you know, the economists on the panel have certainly suggested different sources that we might look to in terms of -- they seem most useful in terms of eliminating potential market power or eliminating the possibility of, you know, physician groups, for example, or physicians having market power. Do they have any suggestions -- I want to ask, you know, not just the economists but everyone. What about trying to affirmatively prove that physicians in a given specialty might have market power? Do you have

any suggestions in terms of types of data, what sorts of projects one should do in that situation?

MS. GUERIN-CALVERT: I would say you do exactly the same thing. I think, speaking for the economists, we have probably been in a variety of cases on the plaintiff side as well as on the defense side, and I think there is nothing better in terms of trying to prove market power to go to the same sources of information and have the best objective as well as qualitative evidence to demonstrate that customers in the effective market lack sufficient alternatives to move enough patients to, and you know, I think that it's something that the same data sources can be used to prove.

MS. NOETHER: Well, and obviously if you can get information on direct effects, namely, the price information, if you've got a managed care company that really thinks it's got a problem with a physician group and they can give you really good data, say that compares a particular market with another market, and you could somehow control for quality of the physicians and all the other things, and you can demonstrate that, in fact, prices are higher in an area when everything else really is constant, then --

MS. LEE: How about in something like a merger

where you do not you are trying to establish that yes, indeed, these two physician groups merging would create market power?

MR. ARGUE: I think it gets back to the same thing, and Meg is absolutely right. It's the same questions. It's the same data. As an economist, what you should be doing is you ask the question, you take the data, try to answer it, and the answer is what it is, and then you go forward and draw your conclusions from that.

It may be that there are relatively few circumstances in which physicians really do possess market power, and that may make it appear that we're always trying to find, you know, ways to defeat that, but I think that really, the objective view of the economist is to identify the theory, the principles that you need to be following, address it with the data that you've got, and then just take whatever comes out of it.

MR. FELLER: I think from a legal standpoint, if you just look at what the law tells you to prove as opposed to the economic theory behind it, they are very similar, and if you are going to try to prove that somebody has market power, whether in a merger context or otherwise, you've got to look at market share, you

have got to look at the ease of entry versus barriers to entry, you look at whether it's a competitive market or not, and ultimately you have to prove they have the ability to raise price above competitive levels without losing business.

I mean, that's really what you're looking at, and that's what the courts say you've got to prove, and I think that as Dave said, that this analysis is pretty much the same for a number of different issues.

MS. LEE: I also want to ask the economists to react a little bit to some of Astrid's comments. What she was saying is that physician services are different from commodities and that it's difficult to apply that same sort of commodity analysis to physician services, and I wanted to ask, you know, are physician services really different? Can we apply the horizontal merger guidelines in the same way we would to a commodity? And in this context, how do you account for differences in reputation and its subjectiveness?

MR. ARGUE: I think obviously there are a lot of components of that question, but from a conceptual standpoint, you should be able to analyze physician services the same way as everything else. You've got the merger guidelines that are constructed to be able to handle a lot of different circumstances. They're

broad enough but yet they focus on the right issues.

It riles certain people, you know, to think of health care as a business and to treat physicians or hospital services as just anything else that's bought and sold. In fact, it is a business, and there are profit-making decisions that are made and, you know, non-profit or for-profit institutions alike.

What's difficult about physician services and hospital services has got a lot to do with the institutions, the third-party payers the principal agent problems, some of these issues that are hard to grapple with, but there's nothing fundamentally different about the antitrust approach that you should take, I think, for physician services as for anything else.

MS. NOETHER: Yeah, I would agree. I think at least from a theoretical standpoint, there are some complexities to health care markets that one needs to take into account, but in some sense, it's just another example of a differentiated product where you have to analyze it in the context of recognizing that no two physicians are going to be perfect substitutes for each other, but that doesn't mean they don't compete and that you can't assess the degree to which they constrain each other's behavior.

I think the more taxing issue is in the empirical analysis. I think that unfortunately, we don't have very good data to be able directly to account for the kinds of quality and other attribute differences across physicians, and you know, that's where it becomes difficult, but that doesn't mean we shouldn't be trying.

MR. WIEGAND: From the legal standpoint, the Supreme Court applied a traditional analysis going way back to Arizona versus Maricopa County.

MR. BYE: I'm sorry, I just lost my place.

Monica, you mentioned a trend, that we're seeing the increased use of allied medical professionals as both substitutes and complements. What I'm interested in is their use as complements and whether we're going to -- and raise this with the other panelists -- but how will that affect physician-patient volume and whether there's going to be a trend over time that will affect a market definition analysis.

MS. NOETHER: Well, I think to the extent they are used as complements, what it does is it extends the number of patients and sort of the supply that a given physician or physician group can provide, and I think physicians recognize this. So, you know, a group of

pediatricians will have a whole bunch of nurse practitioners who handle all the kids who come in with runny noses but nothing serious, and then, you know, sort of save themselves for the more challenging cases that really require the medical expertise.

So, I think essentially it enables what was once a relatively fixed supply of hours in the day that a physician could handle patients to be extended in ways, and so it makes each physician more productive, which says something about maybe expansion that used to not be the case, adding a dimension to potential competition of physicians in any given area.

In other words, it used to be that if you wanted to increase competition in an area, you had to encourage entry one way or another, and it may be now that you can do it by having individual physician groups just expand more.

MS. GUERIN-CALVERT: And I think the logical follow-up reply is this idea that a given HMO, if they're looking to drop certain, say, pediatricians from their panel because they're concerned about their pricing, may be able to replace them with fewer pediatricians than they used to in the past and so thereby discipline.

MR. BYE: Do any of the panelists have any

remarks they'd like to make or closing comments on what we've seen and discussed today?

(No response.)

MR. BYE: In that case, I'd like to thank everyone very much for coming. It's been a great session, really appreciate you devoting your time, and the hearings will continue I believe tomorrow. Thank you.

UNIDENTIFIED SPEAKER: Matthew, are you going to take no questions from the audience?

MR. BYE: Unfortunately, we don't take questions from the floor.

Actually, we do resume at 2:00 this afternoon.

(Whereupon, at 12:15 p.m., a lunch recess was taken.)

AFTERNOON SESSION

(2:00 p.m.)

MR. BERLIN: Okay, I guess we will try to get started here this afternoon. Welcome to the afternoon session of these joint hearings on health care policy. This session will focus on physician information sharing. My name is Bill Berlin, and Randi Boorstein is my co-moderator here today.

Today's topic will probably focus primarily on the recent business review issued by the Division in the Washington State Medical Association matter, the FTC's Dayton advisory opinion, but we hope to explore other aspects of this topic as well that goes beyond those two pieces of prospective guidance.

We will be ending at 5:00 today, if not perhaps a little bit sooner given the somewhat smaller size of our panel.

As far as the usual logistics, interested parties may submit written comments. Those will be ultimately published on the FTC's website. And of course, the transcript, any Power Point presentations and written presentations by the panelists themselves will also be up on the website.

Each panelist, as is our usual procedure, will have approximately ten minutes to speak, but again,

given the smaller size, we won't be too strict with that this afternoon.

After that, we'll take a short break and then engage in a round table discussion that Randi and I will have some questions for our panelists, and we also invite the panelists to ask questions of each other that are presented by the presentations.

I guess I'll turn over the mike now to Randi to introduce our panelists, and I'll extend my thank you now to you all for being here.

MS. BOORSTEIN: Thank you. Welcome, everybody. We're very fortunate today to have four very distinguished panelists who know quite a bit about our subject, some with firsthand knowledge, having been involved in a case. I'll introduce them in the order in which they're going to speak.

Our first panelist today is Roxane Busey. She is a partner in the Chicago firm of Gardner Carton & Douglas. She specializes in antitrust law, litigation and counseling and has been the chair of the antitrust section of the ABA.

Next we will have Gregory Binford from the law firm of Benesch, Friedlander, Coplan & Aronoff in Cleveland, Ohio. He is the co-founder and chair of the health practice group there and was the attorney for

PriMed, the group in Dayton, Ohio.

Then we will have Robert Matthews, who's the president of MediSync Midwest, a management services organization for large physician-owned medical groups, and in that capacity, he's also an executive at PriMed, which is in Dayton, Ohio.

And then finally, we have Robert Leibenluft, who's a partner at Hogan & Hartson specializing in health and antitrust, and he is here on behalf of the Antitrust Coalition for Consumer Choice in Healthcare. That's a group of employers, health plans and others who purchase, manage and deliver health care services. He is going to concentrate primarily on the DOJ advisory opinion to the Washington State Medical Association.

So, with no further adieux, Roxane, we will turn it over to you.

MS. BUSEY: Thank you.

First of all, I would like to thank you for inviting me, and I would like to actually commend both of the agencies for the depth and breadth of these hearings. Following it through the website, I think they've covered just about everything under the sun, and I think that's terrific.

As was stated, the topic today is information

sharing among physicians, and I promised to Bill and Randi that I would at least kick off the discussion, and I thought the best way to do this was to provide just a little bit of background. To me, this is actually a confusing area of the law and one that appropriately deserves some attention.

I think that everyone is aware of the general case law pertaining to the sharing of information. It's not per se illegal to share information. It's subject to a rule of reason analysis. Added to that, I think we have to have the economic perspective, that the more information that is available in a marketplace, the more competitive the marketplace is likely to be, unless there is collusive activity relating to that information sharing.

And of course, in the health care industry, I think it's fairly well known that there is a lack of information or an uneven amount of information among players in the health care industry, and I can illustrate that by asking any of you, do you know how much your doctor charges for an office visit, and do you know how much you pay, and does it vary from the time of the year, depending on whether you have a deductible or not? Again, that information is not as readily available in this market as it might be in

other markets.

The case law, of course, going back to cases that are not particularly in the health care industry, also supports looking at a number of factors when there is no explicit agreement to fix prices, and typically looking at the Supreme Court decisions, including United States versus Container Corp, it's very important to look at the type of information that is being exchanged, the frequency, and then also the market structure, and I want to emphasize that, because that's not something that is particularly emphasized in health care analysis. Sometimes it is; sometimes it isn't.

It's also true, based on the case law, that the more concentrated an industry is, the more likely that the exchange of information may lead to illegal conduct, whether that be a price fix or a boycott.

Having said that, I think it's also important to keep in mind that giving information to the public and particularly to buyers of services is an important function, and to the extent that there are mechanisms and agreements that provide information to the public, to the buying public, this generally should be considered procompetitive, and in this context, instead of focusing on a health care case, I would focus on a

case that the Justice Department brought some time ago relating to the airline industry.

They looked at the airline industry's computer reservation system and said, well, it was okay for the airlines to post their prices on a public system, but once they started to use that system privately between the airlines, then there was an antitrust problem, but the original posting of that information for the benefit of the public was not illegal.

I'd also like to add to that a concept that we're finding in an important case that has been brought involving the medical residency matching program. Here we have a situation where there are two sources of information with respect to medical resident stipends. One of them has to do with the collection of stipends according to the policy statements and their safety zone, and the other has to do with the AMA listing the stipends for all medical residents for those programs that choose to have their stipends listed.

And the question in the case, of course, is that an illegal exchange of information, one that is likely to result in depressed wages or stipends for the medical residents, or is it a procompetitive function where there are many players in the market, in this

case many medical residents and many programs, is it more efficient to have those programs that want to list their salaries do so in a public way?

I think all of this is sort of part of our topic, even though I know we're going to be focusing on the more traditional questions of what do physicians exchange with each other and what do they exchange with payers.

I'd also like to say that having presented this background, which is clearly beyond just the health care industry, it's clear that the agencies in the nineties attempted to synthesize this law and provide us with a number of policy statements relating to the exchange of information, and I'm sure all of you are familiar with them. They relate to statements concerning the collected exchange of nonfee information to purchasers; statement 5 pertaining to the exchange of collective fee information to purchasers; and number 6 pertaining to the collective fee information among providers. And in each of them, there is a safety zone.

One of the questions that I would just sort of like to throw out there is -- and I think it's going to be demonstrated by these letters that have recently been issued -- is whether these policy statements are

sufficient in terms of covering the types of exchanges that are common in the industry, and another question is whether they have had a limiting effect in terms of the exchange of information not only in the health care industry but in other industries that don't have the benefit of specific guidelines and look to these guidelines as the appropriate way in which to exchange information.

In that context, I guess there are two things that I would like to mention with respect to the use of these guidelines. One has come up not so much in the surveying of information, I think that's a pretty well-established area of the law, but with respect to the use of the messenger model, which is I know a topic for another day. Nevertheless, it's pretty clear to me that in dealing with the messenger model, there's always a concern that the messenger will act beyond its scope and will seek to negotiate rather than just simply act as a messenger on behalf of a group of physicians.

However, I wondered if, assuming that the messenger really did fulfill its role, whether the messenger would be in a position to share on an aggregated basis information pertaining to the physicians or some portion of the physicians that it

was representing, and I say that because if you look carefully at I believe it is statement 5, which is the collective provision of fee information to purchasers, there seems to be an exception carved out there for when you're involved in a situation with negotiating, and I'm positing a situation where the messenger was acting as a pure messenger and not negotiating, would the messenger be able to perform the role that perhaps has traditionally been delegated to a third party or to an association in terms of the surveying of fees?

The other thing that I would like to point out with respect to the guidelines has to do with clinical integration. When I went back to look at the guidelines in terms of where clinical integration would fall, it seemed to me that it was clearly covered by statement number 8, which has to do with when you can jointly negotiate and when you cannot, but the information-sharing aspect of clinical integration I don't think is specifically covered by the guidelines. It is only implicitly covered by statement 8, and that might be another area where the agencies might wish to comment.

Having provided just this little bit of background, I guess I would like to begin the discussion by commenting on the two agency letters that

have come out pertaining to providing specific information with respect to insurer reimbursement, and before I do so, I guess I would say I'm not sure this is true, and other panelists can correct me, to my knowledge this is the first time that the agencies, since the policy statements have come out, have issued a business review letter which attempts to deal with the exchange of information that is not covered by a safety zone that is under the rule of reason. I could be wrong about that, but it seems to me that it is very unusual for them to do that.

It may be because they're not asked to do it, but we don't have much advice coming out of the agencies or even too much case law in which there is an attempt to apply a rule of reason analysis to this type of information. To my knowledge, it's also the first time that we've had the agencies bless a situation which involved the reporting of information with respect to specific players as opposed to an aggregate form, and I think this is noteworthy. And just so there's no misunderstanding here, I applaud the agencies for attempting to do this analysis and putting forth this analysis, because first of all, it's not easy to do, and secondly, as I read the two opinions, it wasn't necessarily a very easy decision to state

that it would be okay under each of these circumstances to provide reimbursement information with respect to insurers by specific name, okay?

Having said all of that, there are really two things that I think concerned me about each of the opinions, but for slightly different reasons, and I think I should state what those are. In both cases I was concerned about something that may be beyond the scope of the letter, which had to do with the accuracy of the information that would be provided, and I say that only because it's a complicated area to talk about reimbursement, and in this particular case or in both cases, the reimbursement that would be provided would be provided by the provider, and to my understanding, not by the insurer, and therefore, there could be room for some misstatement of what the reimbursement actually was or some inappropriate comparison in determining, you know, what a service was and what CPT codes apply to it. So, one of the concerns that I had just generally was whether the information that would ultimately be collected and disseminated would be accurate and would not be misleading.

A second issue that I was concerned about was an argument that comes up with respect to rule of reason analysis that is coming from the case law but is

also more clearly articulated in the competitor collaboration guidelines and not so much in the health care policy statements, and that is the concept of is what is being proposed here the least restrictive alternative for what the purpose is, and in both cases, I wondered whether the way in which the data would be reported would, in fact, be the least restrictive means, and I think there will be a lot more discussion about this, but it wasn't clear to me why in each case the insurers had to be identified, and if they had to be identified, why in the Dayton case we were just talking about two insurers and not all of the insurers, and when we were talking about the insurers in the Washington case, why there again we could not use some form of aggregation to provide the information that would be necessary to serve the purpose that was required.

I would also point out that in the two cases I was astounded to read that in Dayton, everybody seems to know everything. The physicians seemed to know what they were being reimbursed at, and the insurers seemed to know what each other was reimbursing the physicians at, and that all seemed to be very well known, whereas in Washington, exactly the opposite was suggested, that really physicians have no idea what kind of

reimbursement they're getting or who they're getting it from and that this would be a mechanism for providing that additional information.

Okay, that's about all that I would like to say as sort of a kick-off to maybe provoke some discussion in terms of the exchanging of information among physicians.

MR. BERLIN: Thank you.

Greg?

MR. BINFORD: First I'd like to thank the Federal Trade Commission and the Department of Justice for inviting me to attend these hearings today on what I personally feel is a very important topic of the sharing of physician information.

As indicated, one of the reasons for my inclusion in the panel was my participation as the counsel to PriMed in obtaining the FTC advisory which involved Dayton, Ohio and was an advisory permitting the setting up by my client of what we've termed a physicians health care advisory group. When I look back at the acronym, Physicians HAG, I think we could rethink the name, but we will work on that later.

In any event, the FTC issued the advisory opinion on February 6th of this year, the essence of which permitted the sharing of information between

competing providers of information involving policies and procedures, including fee reimbursement information by third-party payers in the Dayton health care market.

At the outset, I would like to compliment Judy Moreland at the FTC, who was my primary contact in the process, along with her colleagues and the FTC itself, for what I perceive as a very collaborative process in working toward this advisory opinion. Unlike a number of experiences I have had in seeking advisories where it's more of a black box, you put the proposal in and the response comes out yea or nay, this was more of a user friendly, how can we get to where we both want to be while navigating the difficult restraint of trade issues.

Part of the complaint that I would have is the length of time it took due to this collaborative process, but in the end, I think all parties were served, and the advisory was issued as we had sought within the confines of the law. I can definitely report to the FTC and the Department of Justice that in my opinion, the advisory process works, and I would encourage the FTC to continue in the same constructive manner that it demonstrated in this case, and I believe these hearings reflect both the FTC's and the Department of Justice's intent to do so into the

future. I see that as one of the purposes of these hearings.

I'd like to share with you my perspective on the needs of information sharing by physicians who provide health care services in separate competing practices and the benefits to the community that derives from that process. My perspective comes from my experience as an attorney in the health care industry exclusively really for the last 25 years, actually longer than that, but I can't bear to admit to that in writing.

When I began focusing my practice in health care, my early assignments and projects were the formation of some of the original health maintenance organizations in the Midwest, and I can tell you that at that time, going back about 25 years, at that time, physicians were king of the hill in the medical care marketplace. It was a lovely world for physicians. It was a fee-for-service world where physicians basically set their fees, and those fees were for the most part paid by very passive insurance companies.

Over the course of the ensuing years, however, many factors have intervened, all of which have cumulatively changed dramatically the health care landscape to where we are today and over time has

brought more and more pressure to bear upon both physician fees and physician authority in general and their ability, I might add, to provide quality care. Those factors that intervened over the years include, of course, the advent of Medicare, the advent of managed care, whatever that means. It's come to mean many things to different people today. It certainly means possibly capitated fees, although less so in the market, and I was asking Bob earlier if capitated fees were a dead thing, and he indicated that he thought they were, but certainly deeply discounted fee-for-service fees, burdensome and costly red tape and wholesale diversion of patients. By that I mean the ability of a third-party payer to essentially corral patients into their networks and threaten physicians to move their patients elsewhere, which can constitute a major portion of their existing practice.

Managed care includes, as I indicated, discounted fee-for-service, PPOs, HMOs, Medicare Part C, managed Medicaid, and many other types, but that has been a major, major impact.

To give you an idea of how far we've come, it was very interesting, I just came from a two-day session, a forum held by the American Health Lawyers on fraud and abuse in the health care industry, and one of

the phenomena which has been detected is something which came as a total surprise to me and I think will be of interest going into the future. For as long as I can remember, the focus of regulators, particularly the Department of Justice and the OIG, the Department of Health and Human Services, has been on the physicians for unbundling of charges, which enables them to realize a higher gain, and upcoding of CPT codes, which enables them to get a higher fee for a particular procedure.

Now, there's a growing interest being focused upon the payers -- for the payers doing just the opposite. Instead of unbundling, bundling by computer, downcoding of fees, establishing and changing global periods, and that is, certain medical procedures are authorized by a payer, and if it's necessary to repeat a procedure within a certain period of time, the physician doesn't get compensated for the second procedure or third or whatever. By having a global period, there necessarily involves a deadline, and insurance companies will just extend that deadline unfairly. They're focusing on delays or denials in claim processing, as well as improper determination of medical necessity.

I've been told, at least one of the attorneys I

talked to at this hearing, that there is a movement afoot in the south of putting together a possible class action of physicians, and it's interesting to see this focus change in this regard.

Another of the factors which has brought us to where we are today has been the advent of hospital networks and the acquisition of many hithertofore independent and competing physician practices, which has enabled hospitals to really control the negotiating process of not only their own contracts, but physician contracts, and to control how fees are divided up.

Another factor has been the advent of the national malpractice insurance crisis, as we have seen and we're all aware of, and this has caused a large number of physicians to retire early or to be acquired by a hospital or to move to another jurisdiction, another state, where the malpractice laws are more favorable and the premiums for their malpractice insurance are lower.

Finally, the last factor I'll mention has been the aggregation of third-party payers. Ten or 15 years ago, there were hundreds, if not thousands, of third-party payers across the country. It was not uncommon for any average metropolitan area to have three or four health maintenance organizations, other

private-party payers, et cetera, et cetera. Today, there has been a large aggregation and roll-up of those plans to where most major markets, we have the Uniteds, the Humanas, the Anthems and so on of this world, Dayton being a primary example where, in effect, there are two dominant players in the marketplace and a few minor players who have driven physician fees so low as to actually drive out some subspecialty groups, cause early retirements and inhibit the recruitment of new physicians to the area, all of which inexorably reduces the accessibility to the physicians as well as, Bob will elaborate in a moment, in lowering the overall quality of health care in the area. These are really the harsh realities faced by independent physician groups in many areas across the country.

Along with an understanding of the physician's plight in today's climate, I think it's also important for the regulators to recognize the uniqueness of the health care marketplace. This morning we heard a lot of testimony on the health care marketplace, and it involved a lot of statistics and factors, primarily from economists, as to how to measure the marketplace and so forth and so on, but I didn't hear any description of how the marketplace really works, and it really is a unique market.

Unlike any other, the end users are not the payers, the customers. When was the last time you heard someone say, you know, hey, which cardiothoracic surgeon gives the best operation for the lowest price? In the first place, nobody knows that except perhaps some payers, and the patient cannot possibly make that explanation. It really turns the market upside down. From the time that health care benefits became a job benefit, in effect, in the middle part of the last century and subsequently through government-sponsored programs, such as Medicare and Medicaid, the purchaser in the marketplace is not the user but is instead the third-party payer or what I call the payer/employer/governmental complex.

Historically and for the most part and today, physicians practice in very small groups, what I would almost term mom and pop businesses. Many of my clients consist of a small number of physicians practicing either singly or with a few others, and their spouse may be the business manager. These are not competitors that are equipped to undertake any kind of due diligence, let alone negotiations with the large, powerful and well-financed payer complex to which I have referred.

Groups of independent and competing physicians

must collaborate in order to coordinate and fund their ability to perform the due diligence that I've mentioned on third-party payers in order to make employers who are choosing the payers and paying the bills educated consumers. Independent physician groups need to collaborate primarily in three efforts.

One is in the information-gathering area, including but not limited to fee information. It would also include information involving claims review and medical necessity criteria, as we talked about earlier, in terms of the determination of medical necessity. It would include the gathering of information regarding the representations made by payers to employers versus mandates made to providers, and Bob will I think give us some examples of that.

As to the accuracy of the information that is provided, as Roxane brought up, the process that has been proposed and approved is not just information gathering but information processing, and part of the effort will be to process and attempt to discern the accuracy of the information, and that is in part what feeds the need for collaboration in order to fund that kind of analysis, which is going to have to be undertaken.

In addition to the gathering of the

information, as I just indicated, there will be information analysis, and the third step of the process will be information dissemination and publication, and that is the educational process, the disseminating of the analysis of the information, which can involve fee information, but also communications as to what is covered to patients versus what is mandated to the physicians, et cetera. It will involve public ad campaigns, I think meetings with large employer groups, all in an effort to come to have a more informed buyer in at least this marketplace.

We believe strongly that adequate safeguards can be built into the process through the use of independent third parties, aggregation of information, and prohibitions, strict prohibitions, against any kind of joint bargaining by physicians or boycotts.

As far as Roxane's question about the concerns, whether or not this is the least restrictive means of data, from my perspective, part of the purpose of this is the education of the buyers, the employers, and part of that involves sitting down and saying, here's United Health Plan, here's what we have found. Here's Anthem, here's what we have found. And then let them make the decisions based upon that. It's really the only way to get to that, and frankly, it's necessary to name names,

we believe, again viewing this as an educational process.

And you asked why two and not all, and the intention has never been to limit it to two payers. I think the intention is -- that would probably be a jumping off point, but I think it would be useful to take a close look under the microscope of all meaningful payers in the marketplace and should.

In the end, we believe that enabling competing physician groups to collaborate for the purposes that I've discussed should result in the enhancement as well as the balancing of both the competitiveness and the quality of health care delivered in each unique marketplace, in the instance of ours, in Dayton, Ohio. In the long run, I believe this collaboration should result in an increase certainly in the availability and perhaps the number of physicians and assurance that an adequate number of physicians as well as specialists are represented in any health care marketplace as well as an increase in the efficiency of the operation and the delivery of health care in the relevant marketplace and in the availability and, most important, quality of the health care provided in the covered marketplace.

I think I will thank you at this point.

MR. BERLIN: Thank you very much.

And next, Bob Matthews.

MR. MATTHEWS: I think it's going to need some professional help.

While we're waiting --

MR. BERLIN: This excludes me.

MR. MATTHEWS: Okay, to sort out the IT-savvy from the rest of us.

I, too, thank the FTC and the Department of Justice for having these hearings and the FTC for engaging in a meaningful dialogue that led to the letter that was issued. There you go, I can do it from there.

I operate on the practice side as the executive director of PriMed Physicians, and the things that I'm going to talk about today are really the more practical side -- I'm not an attorney -- of what Greg was just speaking about in our case. This was a case, as we saw it, that was 100 percent about competition, and just to be clear, our medical group and our -- my -- our approach is not to push the limits of price-fixing or boycotting, and frankly, I think the whole move towards an antitrust exemption or physician union thing is pushing a limit that I just consider at least impractical if not a place I want to go. I'm sure I've offended somebody in the medical society part in that

comment, but I think we have to be realistic here.

So, just very briefly, to go through, PriMed's demographics were a 60-physician group owned by partner members with some primary care and specialty, 20 locations around the market. We're very aware of the problems and challenges. We've had a lengthy and ongoing dialogue with Dayton's employers. We've met and worked extensively with General Motors, NCR, Lexus-Nexus and others. We meet regularly now with small employers who are sitting there telling us the world is an ugly place. We see premiums for a family of a thousand dollars per month, $12,000 a year, and at that --

UNIDENTIFIED SPEAKER: It's not working.

MR. MATTHEWS: It's working.

UNIDENTIFIED SPEAKER: Not up on the screen.

MR. MATTHEWS: Well, it's been working for me. Ah, okay.

So, the ongoing dialogue I think we got, $1,000 a family, $12,000 a year. We see employers turning over to patients and saying if it's a thousand dollars -- they're patients to us, so employees to the employer -- it's $500 to you, people have to pull the rip cord and get out of coverage, which we all know generates a concomitant snowball of bad and very down -- very

negative effects.

We also see a number of companies saying at this kind of price, we just have to pull as a company out of the system. So, I'm very well aware that this is a crisis and that we really have to come up with some solutions. In fact, we as a company, PriMed, employs a couple hundred -- 250 people, and we sit around every year and wait with unbelievable anxiety for our rates to come out, and every year they're pretty devastating, and every year we turn more and more to the employees, and we dig deeper into our own pockets. So, there is a real challenge out there, and competition is very much necessary.

Just as a comment, and this is the medical group perspective, who is the customer? If we're talking about value and competition and providing a value to the market, as we see it, the patient is for us the customer. Very often, if we have a recognition it's the employer paying a very substantial or at least half the cost, that's our customer. We do not see the health insurance company as our customer. We see those as transaction warehouses. They serve a role and a function. They are not our customer. And they moderate payments and contracts and things like that, but that's just from our perspective.

And just, again, I don't want us to look like the troglodyte end of the medical community, they're saying, you know, as long as we're doing fine, it doesn't matter how everyone else is. Just at PriMed, we have 15 of our managers, including one physician, who are black belt trained in Six Sigma. We are consistently relooking at every single thing we do with respect to the quality of care. We're stepping up to the plate now to try and make about a $2 million information technology investment.

In dialogue with the employers -- and I'll show you a slide later on -- we're very specifically focusing on patients with chronic disease and patients who might be at risk for chronic disease, because there is going to be data I'm going to show you later that shows that that's about 80 percent of our market dollar going out there. So, we're really looking at that kind of thing.

And we are actually now in the process of talking with employers about managing care. It used to be that insurance companies did transactions, they did contracts, they did the claims and the accounting, and they did something called "managing care," and I'm going to put the most neutral definition on managing care. I'm going to say managing care is any effort,

good or bad, with respect to defining or improving the quality of care or the cost-effectiveness of care.

There was a lot of that going on in the nineties, and some of us actually here today worked together in the context and saw rates go down. In our market, we see the major payers no longer managing care. They fired all their staffs, and they are out of the business of trying to drive quality up or costs down other than through the aggressive contracting. Just in our group, every doctor is required to participate in some sort of quality effort as a requirement.

I want to talk a little bit about the health care environment, because I think unlike some other economic sectors, there are some differences. In a lot of sectors, if I go to Wal-Mart versus Target, I can buy the same thing and I can look at the price and it's the same thing, and there are in health care some instances where the customer can go out and see the value in what I purchased. What am I getting and what am I paying for it?

And I don't know, Roxane, why, but at least in every one of our groups of doctors, you get a statement with how much we charge on every -- on your sheet, and it's actually printed on the form. So, if it's a

mystery in your part of the world, that's different. And there are people who don't have, for example, an insurance benefit, so they pay out of pocket, and they can call my group or someone else's group and say, what does this cost? And they can elect plastic surgery or Botox or those relentless people on night TV selling the eye laser surgeries for your eyes and all that. There's a price. That's a single-service sort of purchase.

A lot, though, the majority of health care purchasing is in a great big roll-up I'm calling it, where the employer pays a PMPM, a per employee or per family price. That includes the entire array of medical care, hospital, pharmacy, doctor, ancillary, lab, da-da-da -da, plus the insurance and the transactional and whatever margin in one price, and I'm going to argue that if you want to promote competition and the value shopping, we have to break that roll-up purchase in which are embedding a whole string of value equations, and people need to be able to see what's inside that box. Otherwise, you have no meaningful power to exercise a purchaser's right.

And I'm going to take as the most simple, standard, economic, you know, what is value? It's quality as a function of cost. If you're making

quality better at the same cost or bringing cost down for the same quality or whatever, that's quality.

In health care, the first thing I want to say is that what we see is a huge decreasing focus of attention, i.e., the leapfrog group and others, on the quality part. People have been beating costs down and around for a long time, but quality is a much bigger part of cost than it needs to be. Successful companies in today's economy know well that in their own business, errors are money lost. They impose a cost.

The New England Journal of Medicine on June 26th of this year published a very strong article, I heartily encourage everyone to read it, in which a RAND study is cited, and basically they're saying that the error rate in our Six Sigma terms, 450,000 errors per million opportunities or 45 percent error rate, and these include both errors of commission, giving someone the wrong drug, the wrong dose, cutting off the wrong foot, as well -- and these are -- one -- recently one University of Michigan epidemiologist told me -- what about the errors of omission, the failure to meet the standard? He said incalculable. The RAND study tried to round it out at 45 percent. So, the employers we speak with know they're paying too much for error, and they know that the cost of care is also of great

concern. So, quality and cost are both important.

But in the matter of cost of care, the things that we so focus on almost exclusively, like the unit cost, how much does a doctor visit cost, how much does the surgical procedure cost, is only one dimension, and we want to point out here today that the real value equation is a whole lot more complex than that.

So, we in Dayton came up with some hypotheses. First we said -- and this isn't so much a hypothesis, I'd say this is moving towards the fact -- our market is controlled by two huge health plans. Both of us -- appear to us to display a sense of impunity. We're right because we have over a quarter of a million members. And we also have a region in which there are two hospital systems. One dominates the north part of the region; one dominates the south part. Everyone pretty much acknowledges you've got to have both networks in. And the health plans have flat out told us, we'll pay doctors after we've paid the hospitals. The money that's left over after we do the hospital deals is how we'll pay you.

What we've also learned and we believe, and this is part of what we're going to study, is that a city competes with other cities for capital and talent. In other words, if you're a doctor coming up and in

Dayton, Ohio, they pay 40 percent less than in Indianapolis, Indiana, and they're two hours apart, guess where the doctors who in the main graduated towards the top of their high school and college class are going to go? They're going to go to the higher-paying market. So, you wind up in a place where you have a competition that goes market to market and that is something sometimes people don't see until things have gotten pretty far out of hand.

Now, here's where -- up until this point, it's pretty much a prelude and some context for where I think we brought the reasoned analysis to the FTC. We were saying that we think the health plans are cutting spending in areas where there's very great damage but it's less visible, and we think that the employer and the patient has the right and need to know that when they make their competitive choice, and we were asking, in essence, the FTC to make a balanced judgment about releasing a small amount of information under very controlled circumstances with respect to physician fees, which is a unit cost, and we were going to follow all the guidelines in order to explode or explore these other realities and see whether we could show them.

Just to look -- and this is -- I hesitated to put this slide in, but if you look at a premium of $235

per month at the bottom of the first -- the middle column there, total premium, that's comprised of about $79 and change in hospital costs, $30 in pharmacy, $65 in physicians, and you can see, totaling up to $195. Now, in Dayton, Ohio, that is probably about an average premium. There are companies that are paying $400 a month, and there probably are some companies that are paying $199 or something under $200, but in the main, smaller companies are paying the high side of -- more than that, and the large companies are paying that or slightly less, because they have more clout, and you can see there the percentages.

So, the question came then that if we could draw the data, what do we think we could show? We thought we could show that insurance companies make deliberate decisions in creating their products and their contracts which have very negative results on cost as well as on quality, and so, for example, that they treat our market significantly different than they do other markets around the country or even adjacent, that some insurance companies use subterfuge to withhold care that is necessary for patients.

That's a point we want to prove that I don't think the FTC -- we didn't need the FTC to do that. That's not -- that's an allegation we could have

drawn, gathered data and made to the public without the FTC ruling; that some insurance companies make decisions that save pennies today but that will significantly increase -- and let me give you a simple example of that, and as the session goes on, we may get into others.

In Dayton, Ohio, cardiology and orthopedics in rough terms get paid 115 percent of RBRVS, 15 percent over Medicare, and those are procedural specialties. They're highly visible. If the ambulance rolls into the emergency room and there's no cardiologist, that would make the night TV. Whereas endocrinology, rheumatology, primary care are paid we think -- these are rounded numbers -- 5 percent below Medicare. They're not procedural, they're not highly visible.

Now, in our work with General Motors and others, they can go on for hours about the cost of poorly managed diabetes, who treats diabetes, especially the brittle cases, and their chronology, and if you don't keep your diabetes managed, there is a ton of medical literature that says that you're going to wind up having a stroke, a heart attack, blow your renal artery and get on -- I mean, you know, just the untoward consequences of poorly controlled diabetes. In fact, they've quantified that for -- there's a

long-term measure of glucose control called the glycohemoglobin. Every half point of that you reduce saves some thousands of dollars in downstream care.

So, to be paying -- and what we found in our market is that our -- we didn't have endocrinology in our group, and the one we used left and moved to another town. Now, these cases are going to wind up in the ER in a heart attack or a stroke, and in our market, you're not going to be able to see an endocrinologist in the next couple of months, and the same is true with rheumatology.

I was just on the phone last night with rheumatology. We are way underserved. We have very strong financial people on our team. We can't make a competitive offer. We need them. We're desperate. And you can't send them to Cincinnati, it's in more or less the same shape. Now you're telling people go to Columbus, go to Indianapolis, go to someplace where they're better paid. And I think that the health plans need to be held accountable for that, because if you don't treat rheumatoid problems, you are going to wind up popping new hips and knees and everything into everybody three years down the line, and that's a -- now, I -- we needed to gather this data. We have it -- we have data, but if we're going to go out to the

public, you want to have that. So, when we said let us go out and gather data, it was to show these kinds of stories, and this is only one sample, but untreated chronic disease is bad, and it is plain stupid in our view to knock down -- and let me put that in context.

If you take the $65 per year that are spent in this mock average PMPM that I gave you and break it out by specialty, you know, cardiology is 237 and orthopedics is 466. Endocrinology is 13 cents. So, if you give somebody a 20 percent increase to get them into town, what's 13 cents out of a PMPM of 235? Rheumatology comes in at a big -- almost a quarter. It's the dumbest thing you'd ever want to see, but you've got to have data to tell the story, and we went to the FTC, in essence, to gather the data that we felt was needed.

This is kind of a classic chart showing that 20 percent of the patients in the top of the pyramid are spending 82 percent of the dollars. Who are they? Diabetics, people with rheumatoid -- the chronic disease patients. Eighty percent of the people spend 18 percent of the money. So, the very -- we want to go to the public and say, you know, we're not opposed to health plans trying to get the costs down. We just want them to be smart about. And what we think that we

can show is that the harm that's being done to our delivery system today, it costs money. It's penny-wise and pound-foolish, and we are very worried that if the market goes further and further down, it may take us quite a long time to recover.

We're all mindful that we're on the front cusp of the baby boom generation and that if we lose ground in the market, get a terrible reputation, lose our specialists, it could take us quite a long time to get that back in place.

So, that is what we asked the FTC to do. On the one hand, could you look at this small amount of disclosure on the -- against looking at the whole guts, as it were, of health care decision-making that certain large insurance companies are making.

I won't go into these now, because my time is I'm sure up, but you know, there's some questions that that I think fall out of this anyway. What principles apply if you're going to look at discrete information in order to sort of open up the larger question of where premium dollar goes? Is there a certain kind of information that are fairly well known? What meaning does the fact that that information is fairly well known mean when coming to publish it?

This is a tangent, but around the country I see

that there's some antitrust issue here when hospitals go out and purchase large numbers of physicians and now come to the table with these owned hospital networks. They're allowed to lose money on their physician networks at very large rates often, and then they also drive the market in interesting ways, because they say to the carriers, you know, we've got a hundred doctors, we've got the hospital, if we get out, you are going to be over a barrel.

I'm not sure we want to drive a lot of the physicians into these hospital entities, but the way the rules are set today, it's worth more to the hospitals to have them and lose money. When we talk about losing money, a lot of hospitals today are considering it a homerun if you only lose $75,000 per year in operating expenses for every doctor you own. It was a hundred and a quarter three years ago, but they have kind of tightened it up a little bit.

So, those are my thoughts.

MR. BERLIN: Bob Leibenluft, if you will give your address, please.

MR. MATTHEWS: I don't know where you are up there.

MR. LEIBENLUFT: Thank you. I'd like to again express my appreciation in having the opportunity to be

here this afternoon. I'm here on behalf of the Antitrust Coalition for Consumer Choice in Healthcare, and it's a long name for something which is composed of employers, health plans, providers and others, and what we were really formed to do, this coalition, was in response to some proposals to create an antitrust exemption for physician joint negotiation, but the group has been concerned about ensuring that there will be competitive markets in health care, and so they in particular reacted to the Washington State Medical Association business review letter which came out about almost exactly a year ago, and that's something that I'm going to want to address today.

By the way, I was just frightened by this thought, and I still can't get it out of my head, that doctors, when faced with two decisions about medical care, will make the wrong one almost half the time. That just seems staggering. I don't know what to do going home, actually.

MR. MATTHEWS: Drive carefully.

MR. LEIBENLUFT: And that raises a whole bunch of other questions.

But let me focus here on the matter at hand, which is access to information. The Coalition agrees and I agree certainly with Roxane and others, that

access to information by buyers and sellers is vital to ensure a competitive market. I don't think there's any real debate about that. But there is some concern that information sharing can lead to price stabilization and collusion. That's our role here, because there is a tension, there is a balance, and the question is, how do we sort that out?

And in particular, the reason why I'm focusing on this business review letter is the concern about sending the wrong message, perhaps, to the health care market. With physician services, I think there's a particular concern because there has been numerous instances, and the FTC this year has come out with about a dozen enforcement actions with respect to what should be otherwise be competing physicians who have colluded, coordinated their actions with respect to health care plans and raised their prices, and so there's a real issue out there for some physicians. Obviously it's not all physicians, but it's something there that we need to be sensitive about.

I want to really focus in detail on this one business review letter. I'm going to be knocking DOJ here, and it's nothing personal, but it's just something that I think is a good example, and I was involved when I was at the FTC writing advisory

opinions that you have to be very careful on how these are done, and what I'm trying to be here is constructive in the sense of where there's a real need for very close analysis. I think here, on the Washington State business review letter, there are some things that to me really didn't quite get together.

What did WSMA do? They represented 75 percent of Washington state physicians, and they proposed an information gathering and dissemination program, and as I'll explain in the course of this, I think there were few real good procompetitive justifications for the program. So, on one side, I don't think the procompetitive justifications -- if you look at them closely -- held up, and on the other side, I think there's a real danger of collusion and stabilization of prices, and there really were not adequate safeguards against that.

So, the bottom line is that I think it has attempted the possibility of sending out a green light. All these review letters and advisory opinions, since there are so few cases, everybody tries to divine, what does this mean, what's the guidance in it, and I think here the guidance might -- people may take away the wrong message.

Okay, what WSMA proposed to do was to publish

two types of statistics. One was the average amount charged for particular services by Washington physicians, and so that's really what's their average price charged, and that was going to be done essentially in a way that would be covered by statement 6 of the guidelines, the safety zone. So, there were going to be enough of them, this was going to be data that was more than three months old, the specific physicians were not going to be disclosed. That's something that was not particularly a concern of ours. That's consistent with the safety zones. We weren't really raising concerns about that.

But the other part we were, and that was they were also going to be publishing the average reimbursement for specific services by health insurer and by geographic region. So, people would be able to know how much the Blue Cross plan or the Aetna plan or the CIGNA, whoever was out there, was paying in Seattle or Spokane for certain specific CPT codes, and that was not covered by the safety zone, and that's what we're concerned about.

The business review letter itself recognizes several reasons for concern. It could facilitate collusion in the sale of physician services. By identifying specific insurers, it could be the means of

targeting a boycott, identifying who is the lowest payer across all plans and therefore be a means of facilitating a boycott, or facilitate an agreement among physicians on a starting point for negotiations with insurers.

Again, if you are a physician and you know that the average payment rate was 20 percent more than what you were willing to accept last year, what are you going to do next time around? You are going to bring up your price to what everybody else was charging. So, it's a price stabilization issue.

And these kinds of concerns have been addressed in the past by enforcement actions by DOJ, one involving OB/GYNs in Georgia in 1991, another involving on the purchasing side information about entry-level wages for nurses amongst health care providers in Utah in 1994. So, it's an issue that has come up before, which is why we were, quite frankly, surprised by the way the business review letter was written.

Okay, I'm going to go through -- basically there were two justifications that WSMA proposed to justify its conduct. One is it said it's going to allow a better and less costly comparison of insurers' fee schedules, and what WSMA said was, "Providers often do not receive fee schedules from insurers, and they

don't know what they're being paid for specific procedures." That was their assertion.

At least the folks in the Coalition that I've talked to and people in health plans were quite surprised about that. You know, it is the case that the average physician, just like the average patient may not know what a particular procedure is reimbursed at, physicians do tend to know what Medicare pays, and they do tend to know what 120 percent of RBRVS is or what 130 percent is or what 140 percent is. That's the number they care about.

You know, if you're an OB/GYN, you may care about what is a normal delivery. You know, certain procedures they may also care about. They know what that number is, and they look for that in the contracts, and that number is in the contracts. There may be revisions. There may be allowed some other language in contracts that they may not be as familiar with, but my experience has been physicians know about -- particularly when payers are paying off of a Medicare fee schedule, which is very typical nowadays, they know what a health plan is offering, and that's what the negotiation is all about, and that's what they're concerned about.

Second, remember, the survey that was going to

be done was going to be what are the payers paying generally on the average for other physicians? So, it's not going to tell me what a payer is offering me; it's going to tell me what my competitors are accepting. So, I'm not quite sure how this really tells the average physician more about what the insurer is going to be paying that physician.

And thirdly, ironically, Washington State is one of the few states that has a law that actually allows for some joint nonprice negotiation on the part of physicians, and the Washington State Medical Association has a very active service advising physicians about contracts and interpretations and so forth.

By the way, I think that's a good idea. That's an information-sharing role that I think it's reasonable for physicians to be able to understand their contracts and information that will explain to them, as long as it doesn't facilitate collusion, personally I think is fine.

The second justification was a very brief one. It said it will provide -- I kind of have two quotes -- three quotes in this quote -- somewhere it starts and ends, I'm not quite sure -- "will provide information to other parties, such as insurers,

employers and academic researchers, and therefore will allow each of them to take better informed actions," but nowhere in the business review letter does it say what kind of information, to what parties, why do they need it, what are they going to be informed about, whether any of these parties have sought such information, and most importantly, whether the information could be provided in a way with a less potential for anticompetitive effects.

So, I have some issues with the Dayton opinion as well, but Dayton I think, as you heard, it was a very clear message here about what the requester wanted to do with the information. This seemed to be kind of, well, somebody has asked or it might be useful to somebody. If there was no anticompetitive risk associated with that, well, then maybe there's no problem with it, but as I'm going to explain right now, there is a potential for problems, and we talked about those before, the collusion and others.

Now, WSMA said, okay, here's a number of reasons why you shouldn't be worried about this. The first they said is the physician marketplace is relatively unconcentrated. It is a big state, and there are a lot of doctors, but as we all know, when you look at physician services -- from this morning we

know this -- you have to look at it by specialty and by location. One can't just say it's an unconcentrated market statewide, because physicians generally don't compete in a statewide market.

Certainly in rural areas of Washington, there are very few physicians in some of those areas, and a very small number of them could constitute 100 percent of the relevant geographic and product market. So, that really has to be analyzed on a local basis.

Now, in the Dayton opinion, that opinion was just geared towards Dayton, and again, I don't want to say one opinion was good and one was bad, but it's just as a contrast, that advisory opinion was much more narrowly tailored to one market. This said, generally, we accept the notion that physician markets are -- or Washington State, you know, this is a region where we should have less of a concern because this is unconcentrated.

Lastly here, we see that, you know, Washington State Medical Association, again, was 75 percent itself of all doctors, and they said they were going to make their results available to everybody. So, all the physicians in the entire state would have access to the information. The data was going to be at least three months old, and that was going to be another assurance.

Now, I think that may make a lot of sense if we're talking about wheat prices and, you know, a wheat price or oil prices, gas prices, three months old, that's useless to anybody who wants to collude, but with physician services, those prices tend to be negotiated at most once a year. So, we're talking about a price that's three months old, that's likely to be the current price, and it's likely the price that's going to be out there for a while, and it's also going to likely be the market that's going to be -- what the new negotiations are going to be built on.

The next assurance, no individual providers' data will be disseminated, only the average reimbursement data will be furnished, but this could still provide a common starting point for negotiations and therefore targets for a group boycott. And here, I think Roxane mentioned the messenger model, which I think is an interesting thing for us to think about. Whether or not you agree with the agency's view of the messenger model, the logic behind a strict interpretation of the messenger model, which is, for example, the agencies would say it's not proper under a messenger model for the messenger to come up with a starting point or an average and have people opt in, a number which people could opt in or opt out of.

The concern there is everybody comes up to that number, because they know that number is being used as sort of a benchmark, and so if you're below that benchmark, you'd come up. I would suggest that we have the same concern here. If there's a target out there, a number out there which gives everybody an average for a particular payer, then that becomes a useful benchmark for collusion.

And in fact, going back almost 20 years ago, I looked at some of the older staff advisory opinions, and you know, WSMA's defense here was that average was better. Well, this was language suggesting that dissemination of the average prices charged for particular procedures can be more troublesome from an antitrust standpoint as opposed to dissemination of a range of charges. Why? Because the average price -- and this is involving currently charges, so there's a distinction, but still provides basically a danger in the dissemination of average price information to physicians who currently charge varying prices and may provide services at varying levels of quality -- remember, we have these doctors who are at least wrong half the time -- can be that the stated average made through tacit or express agreements serve as a focal point for artificial price conformity.

For example, price dissemination of an average price may be part of a competitors' reaching a common understanding that the stated average will become the price they usually will charge, or even the minimum price charged, for a particular product or service. So, an average to me doesn't solve the problem. It makes it worse.

Another assurance, WSMA said, look, it's going to be difficult to monitor a price-fixing agreement, because agreement among physicians is unlikely because the same service often is categorized by different CPT codes or combinations of codes. Well, if that's the case, then what use is the survey at all? I mean, if what you're saying is that sort of, you know, these CPT codes and how people code something differs so much from one physician to the next, then it seems to me that it's garbage in, garbage out, and you can't have it both ways. If it's going to be a valuable survey, you've got to say the CPT code for which you're gathering the information means something and there's a common understanding. I think there generally is a common understanding, and I think for that reason we have concern about the potential collusion, but you can't have it both ways.

The last concern here is that -- I mean, the

payers -- if you talk to insurers, to health plans, the rates they get when they negotiate with hospitals or physicians is a real concern, that that's kept confidential. I mean, the last thing in the world -- they're bargaining with somebody and it's two-way bargaining when they do bargain with groups, and they want to have those rates kept confidential, and here is a mechanism basically where that information would be disclosed to everybody in the market.

So, in conclusion, again, we just want to say, you know, the coalition has supported the enforcement efforts of the FTC and the Department of Justice in ensuring competitive health care markets, and a really important role of the agencies is providing those advisory opinions and business review letters, and we recognize -- I know having been there, it's not easy always to write these opinions. You have to deal with them, and people raise the tough questions. We are just urging that care be given that not a green light or even a yellow light be sent out that might encourage providers to engage in anticompetitive activities.

Thanks.

MR. BERLIN: Thank you very much.

I think we will take a ten-minute break, come back at 3:30 and begin our moderated discussion.

(A brief recess was taken.)

MS. BOORSTEIN: Okay, everybody, we're going to get started again, and I think the way we'll start the discussion is by giving each of our panelists a chance to respond to everything that they've heard. So, once again, we will follow the same order, and we'll start with Roxane.

MS. BUSEY: Well, I actually just wanted to pose some questions and maybe have a little bit of a discussion, and I would raise the same question that I raised before, which is in the Dayton letter, where there was an effort to -- I thought it was identified as two, but I have been corrected to say all, I think all insurers?

MR. BINFORD: Yes.

MS. BUSEY: Why it would need to be provided by naming the individual insurer rather than by aggregating the information, and so let me just explain why I'm confused.

It would seem to me that when the purpose of what you're trying to show is that there is low reimbursement in the area and that that low reimbursement has caused a reaction in terms of the ability to maintain and recruit physicians, and it doesn't seem to me that you need to show that it's by

one insurer or another, it doesn't really matter. What's most important is that that's the way it is really from all or substantially all of the insurers.

So, my question is, particularly in the area of the distribution as opposed to the collection, collection might have to be done from the provider by individual insurer, but my question is, why in the distribution can't it be simply an aggregate figure? And that goes back to my -- the legal argument is, wouldn't that be less restrictive, because -- let me just finish the thought -- because if you don't name a particular insurer, you're not as likely to have any kind of a boycott of a particular insurer. You're just likely to have information pertaining to insurance reimbursement overall.

MR. BINFORD: And I think that's a fair concern, and let me take the first crack at responding to it, and then I'll see what Bob has to say on the same issue.

Number one, we don't know what information actually we're going to glean out of this process until we have it, and therefore, if we find information gathered that points out something particularly unacceptable or bad or having a negative effect upon quality or anything else of the health care delivery

system in Dayton, we want to be able to actually finger that provider and tell at least the consumers, the employer groups, hey, here's a problem, and we've identified it. We at least want to keep that door open.

If that's not necessary, then I see no need in doing it, but there's certainly that possibility, and it may be that that is information which is shared with employer groups and may not need be shared with the physicians themselves. That's another decision which will be made I think going down that road, which would certainly avoid the issue of boycotting, unless you have boycotting by employer groups, but I don't think you're going to have as much of that.

Bob?

MR. MATTHEWS: Yes, I envision our process going in a direction where we could go to an employer and to their employees and say, you know, with this insurance plan X, we cannot get an endocrinologist in town, whereas with Y, we can afford at their rates to bring one into town. Which one do you want to choose? And here's the importance of managing diabetes and here -- you know, all that sort of stuff. And you know, we don't have any endocrinologists in our group. I'm not out here trying to -- I'm just trying to say that when

our doctors are trying to take care of patients and they don't have that resource available, and I'll add as an addendum, you know, certain specialties and certain procedures shouldn't be in every town for quality and cost purposes, you don't need it, but endocrinology and rheumatology, you don't want people driving two hours for that. Rare brain surgeries, they can drive four hours, but this kind of routine care for a brittle patient -- so, I would like to be able to say, yes, this company in particular has taken a step or action which precludes your getting this care in a timely basis or at all in this town, and I think that as a purchaser now I'd like to know that, because that's pretty important.

MS. BUSEY: Do you want me to respond or, Bob, do you want to respond to that?

MR. LEIBENLUFT: I guess I'm questioning as a purchaser -- I think Roxane's question, by the way, was right on. I had the same concern, is there a narrower or less restrictive alternative. Even less restrictive than that, isn't the key thing that you're trying to tell the employers is, there's no endocrinologist in town, how important that is, so why do you need to know how much the payers are paying for that? You can just show -- there's data about how

many endocrinologists are in town, and you can look at that, and you can say, here, per hundred thousand people in Dayton, there are none of these specialties. That's a real problem, and the employers should care about that. I'm not quite sure why it's so important to get to the intermediate step of how much each payer is paying.

MR. MATTHEWS: Well, I would argue the opposite. I mean, we live in a world of data where as a tool of analysis could say, you know, cause and effect are co-relative relationships, and if a large insurance company elects -- and by the way, if anyone wants to -- there is at least one endocrinologist in town, we're terrifically short, but I don't want to make the absolute -- we're terrifically short, and you should have X per hundred thousand, and we have less than that, and we're waiting three months, but that didn't happen because of anonymous forces in the universe. You know, I mean, this wasn't something the archangels designed. It happened as a direct consequence or result of actions and behaviors on the part of particular insurance companies in the assembling and putting together of their product.

MR. LEIBENLUFT: But if the market works -- I mean, shouldn't the employers be saying -- you go to

the employer and say, endocrinologists are really important, and employers understand that. You have shown them your data. They go to their health plans and say, we want to have X number of endocrinologists on our panel, and if the health plans say, gee, we don't have them, then I would think the dialogue would be between the employer and the health plan. How come? Why don't you have more? Maybe they need to raise their rates so more will come back into town. That's the way lots of markets work. I'm not quite sure why you need necessarily to have people surveying what the payers are paying.

MR. MATTHEWS: Well, the reason for the survey is so that you have the ability to demonstrate that, A, this is, in fact, the case, we don't have any. We know they're not in town. B, you have the opportunity to find out that this isn't the case in other places where they happen to have endocrinologists. And C, you have the ability to -- I mean, I experience in situations where we buy things the opposite of what you're describing.

If Siemens and GE are trying to sell me something, they're very quick to tear apart the other guy's product and say it doesn't have this, it does have that. This is where value can be found in a

purchase, and that's part of the search for value in a competitive marketplace.

MS. BOORSTEIN: Just to follow up a little bit on that, usually you would think -- you were saying that endocrinologists lead to lower costs because then you don't have people needing to go to cardiologists later when they get sick because their diseases aren't managed, but presumably it costs the insurance companies more when people get really sick, so why aren't they internally making those calculations that will ultimately save them money?

MR. MATTHEWS: That's a very good question, and you know, first off, we haven't finished the whole thing, but I can tell you what my working hypothesis is, and I have seen this happen, and I recently had a conversation with someone who it turns out is in the audience here today who's eight states away, so there is no antitrust problem here, and those are situations where some of the people in health plans are playing a very short game, quarter by quarter.

These are large, now public companies, and the two that we're dealing with -- and I mean, somebody told me a story, and this matches my own experience, just condenses it, where they laid out a bunch of data, and the guy said, yeah, but my personal bonus for this

year is based on X, you know, from an insurance company, and again, I think that if you have evidence or you can accrue evidence that shows through analysis that to the customer, who in this case is the large employer, the midsize or the small employer, that people are making very silly decisions in a short game against very significant increases in cost in the large game, then that's something that ought to be brought to the public attention. So, that's the largest reason I think.

The other -- and it's probably not a whole lot less nefarious -- that I find is, you know, there was a time in United States history where there was actually a collusion between physicians and insurance companies to bring costs up, because insurance companies -- and hospitals. Insurance companies got paid as a percentage of premiums. So, if the rate went up every year, so did their revenue, and it's been argued in some recent places where I'm -- that we're moving more back to that percentage of premium.

They have gotten out of the business of managing care, controlling costs and managing the quality, and they're just -- you know, if things float up, they don't like to lose business, but if things float up and they're on a percent basis -- now, that's

pretty nefarious and dark, and I won't make -- say that I can prove that, but I'm watching decisions be made which really defy my -- any rational basis, and I think they -- when we go to the smarter large employers, they are chagrined about this. It's very alarming to them.

MS. BUSEY: Well, I don't want to dwell on that too much, but I guess I would just ask one more related question, which is you both are in the position where you represent, if I understood it correctly, a multispecialty group.

MR. MATTHEWS: Yes.

MS. BUSEY: So, you have the advantage of some of this information that individual physicians may not have, and by that I mean the comparison between physicians, what they're paid.

MR. MATTHEWS: Well, we can tell in Dayton what primary care groups are paid. You know, the large insurers have told us we're paying everyone on the same basis a number of times. Someone asked earlier today, how does everyone know? They may be lying, but that's what they've told us repeatedly. So, I can look and see now what primary cares are being paid, and I can extrapolate from that, but I think that it would be -- if you're going to go out and make a case in public

with data and facts, I would like to have a sample size of more than one group, and I think that even though the assertion's been made that everyone's treated the same, we've already discovered that that's not true. So, when you gather data, you get a chance to show that.

Now, the other thing is to go to markets that are outside our area and say, is it, in fact, the case? Now, we've lost three or four doctors who have moved out of town to other cities where doctors are paid more, but is that enough proof to assert that there's a substantial difference, or do you take an average, a weighted average from our market and you compare it to a weighted -- you know, some other markets? And you start to say, yep, that's really true. Because if you're going to the press or you're going to an employer and you're going to make an assertion, I really want to have the facts nailed down pretty hard to the floor, lest be held liable for --

MS. BUSEY: Well, yeah, I understand that. Again, I think that in my mind there's just a difference between providing information that goes to what, you know, the entire market is doing versus pointing your finger at one particular payer, in part because I don't know that pointing your finger at one

particular payer helps your case I guess is what I'm trying to say.

In other words, in order for you to be able to show that physicians are leaving because they're not adequately paid in comparison to other markets, it seems to me that's got to be overall. It's got to be overall in your market they're not paid appropriately. So, I'm having a problem with that, but again, I don't want to dwell on it. It's just to me, when I was reading this, I thought that the way it's set up is that it seems to me that it could result in a more anticompetitive effect -- could, you know, that's a judgment call -- than if it had been set up in a way that it didn't identify individual insurers, and I thought that you could achieve maybe not 100 percent of what you're trying to achieve but a large percentage of what you're trying to achieve by a more aggregated approach.

Actually, I had the same reaction to the Washington letter, and I said that before, and I would just like to spell it out a little bit more.

The Washington letter is a little bit more a mystery because of this -- the point of -- that I made and then Bob sort of confirmed, which is the letter says that the doctors don't really understand

what their reimbursement is, and Bob even made the point of saying, well, then, how is this specific information going to help them?

I guess where I would start is from the point that I think that physicians do need to know whether they -- how they determine it is the question, but they do need to know what comparative reimbursement is. I mean, how can they decide that they're going to participate in a plan if they don't know what they're being paid and they don't know how to compare it to another plan? It seems to me that's something that they've got to get a handle on.

Now, they can get a handle on that individually, okay, presumably, because they're contacted by all or most of the plans, or it seems to me if you're going to go to a mechanism like what was done for the Washington Medical Association, again, I don't understand why you couldn't do it by aggregation. In other words, say to a physician, okay, you're a primary care physician, and you may not know what others are being reimbursed, so we are going to tell you what the range of reimbursement is from all insurers. We're going to give you the low and we're going to give you the high, and you're going to have to figure out what you're reimbursed -- okay, people are

shaking their head. Maybe you can -- are they allowed to comment?

MR. BERLIN: No, they are only allowed to shake their head.

MS. BUSEY: All right, you know --

UNIDENTIFIED SPEAKER: How are you supposed to run your business if you don't know what you're paid?

MS. BUSEY: Well, no, but why don't you know what you're paid? You're a physician. You're supposed -- I mean, you sign a contract. I mean, the physician organizations that I've been involved with, there's been a mechanism where you could call and inquire if you were a physician. So, for example, if you were told your contract is 110 percent of Medicare schedule, and you didn't know what that meant, for example, you could call and find out, and they would actually tell you. So, I'm a little bit at a loss as to why that's not possible.

UNIDENTIFIED SPEAKER: Health plans can unilaterally change the fees in many contracts, and they do so willy-nilly, and they don't tell anybody about it.

MS. BUSEY: Well, that's a separate issue, that goes to contracting, and I have seen contracts like that that are one-sided, but those need to be changed.

I mean, that's just a simple way to change that. That's a whole separate issue. Unilateral changes in contract are hard to believe in any industry, that one party would say, okay, whatever you change your price to I'm willing to agree to, but that seems to me to be a separate issue in terms of how are they going to figure out what the plan is offering and whether that is a plan that they want to participate in.

MR. LEIBENLUFT: And it's not clear how they are going to answer that survey if they don't know what they're being paid either. I guess what Roxane -- I agree with everything so far that Roxane has said, and I think, for example, I agree that physicians should be able to know what they're being paid. There's no question about that. I think there are procompetitive ways where somebody could come together and provide physicians information about what the plans are offering, what the plans are offering, and allow physicians to compare apples to apples for a set of CPT codes, and then physicians can independently decide what they want to do, but that's different from saying, here's what people are willing to accept from the plans, and I think that's the real difference between what Washington State Medical Association's business review goes to and what I think a procompetitive way

is.

I think the procompetitive way is give people a mechanism for learning what the alternatives are, and they, as sellers of their services, can decide with whom they want to contract. That's procompetitive. I don't see why they need to know what their competitors are accepting. That's a difference.

MR. BINFORD: And I agree with Roxane in that it is a contractual issue, where you just agree to accept whatever somebody is going to pay you, although I have seen it done, but with regard to the fees I have seen in negotiations where a third-party payer will share with the group a sampling of their CPT codes, but their entire fee schedule is sacrosanct, and they will not share the information no matter how hard you negotiate.

MS. BUSEY: I don't have a comment. I mean, that seems to me to be -- then you walk away from that. That seems to be my comment.

MR. BERLIN: Yeah, let me I think ask a related question and probably mainly for you, Bob, because there may be a practical answer to it that I'm missing -- the other Bob.

MR. MATTHEWS: Too many Bobs on this side.

MR. BERLIN: Exactly. Sort of juxtaposing the

stated justification in the Washington State letter on the facts as stated in the Dayton letter, and that justification is to have a better and less costly comparison of insurers' fee schedules, is that something that is as useful or as necessary in a market like Dayton that is, as you've stated, dominated by two health plans or perhaps as necessary, you know, in other markets if we've seen, as we have, the amount of consolidation among payers and whatnot?

Is there really that sort of -- and again, I may be missing something, but is there that diversity or confusing amount of information out there that it's truly necessary for this particular point?

MR. MATTHEWS: Well, just to make the practical point -- and there are different ways you can get at information, but in our -- in contracting with health plans, both the large players that I deal with in Dayton, Ohio refuse to show you their fee schedule. They will show you 10 or 15 codes, and if you beg and whine enough, they may show you another 10, but they will not disclose their full fee schedule to you, and you can say, well, just don't enter those contracts, but to somebody's comment here, the commercial market in Dayton is 90 percent controlled by two players.

So, either one of them, to your earlier point,

by taking an action can pretty much preclude endocrinology, and at that kind of market domination, which they were allowed to acquire through mergers and, you know, whatever in part -- part of it is market growth, but part of it was United buying Western Ohio and all of a sudden being a gorilla in town.

Now, when it comes to looking at data and understanding what you're being paid, at one level, every service you provide produces an EOB, an explanation of benefits, with a remit, and there is a way to aggregate up to -- it's costly and time-consuming and painstaking, and you don't always know prospectively, you have got to do one to find out, and so there -- in some form or fashion, you can figure out what you're getting paid, but that's pretty expensive and pretty time-consuming.

If you are in a small town and you're in a two-doctor office, the analysis required of that would be not inconsiderable, and the kind of expertise you may need on the accounting or business operations side may be beyond the practical scope of your company. If you're in a 60-doctor group with CPAs, you know, we can do it that way, but still, we're paying somebody to go mine this data out and figure it, and you have got to look up the original EOB because they break things out

and do alloweds and contractuals and self-pays, you know, patient portion is different case by case, and you've got to calculate all that. You can theoretically do it. I don't think it's a very good way to do business.

I guess I understand some of the other Bob's concerns, but I would say that in a -- you know, maybe if you're in 150-doctor group in Seattle, this isn't such a big issue, but if you're out there practicing away in a three-doctor town and you don't want to have a staff behind you of ten figuring your contracts out with multiple payers, some of this doesn't look psychotic or elaborate to me in its effort. It's practical.

Now, I understand that there are some other issues, but what they're really talking about is pretty broadly construed in terms of what is the average fee that doctors are charging and what is the range, in essence, of the payments. That allows you to mark yourself in some context. And I'm not a lawyer, but I know that other businesses do spend a lot of resources trying to figure out where they are in price against the market, and I don't think all that is illegal. I think there are legal ways to do it and not legal ways to do it, but you know, I mean, I know for a fact that

GE knows how much Siemens sells MRIs for, and so it's not exactly nuts that Dr. Smith or Jones in Walla Walla, Washington, wants to know what doctors around the state are doing, because he doesn't probably have a staff of many, many people to help him sort all that through.

MR. LEIBENLUFT: Can I say a couple things on that?

First of all, I don't think Siemens knows how much -- who was the competitor, GE?

MR. MATTHEWS: GE.

MR. LEIBENLUFT: -- is selling -- discounting, what the actual list rates are. They may know the list price, but I don't suspect they know the discounted price to hospitals -- you're laughing? Maybe I'm wrong.

UNIDENTIFIED SPEAKER: It doesn't work like that at all.

MR. LEIBENLUFT: Okay, maybe they all don't negotiate, I don't know, but it seems to me that in many businesses, people who sell don't let their customers know what price they're offering to other purchasers.

The second thing is, on the Washington State Medical, again coming back, if there's a problem with

doctors knowing what they're getting paid, that may be an issue, but you don't solve it by surveying them, because if they don't know what they're getting paid, what number are they giving to the survey about the average reimbursement amount? So, there's a disconnect here. Either they do know or they don't know what they're getting paid.

Maybe I don't understand what was being proposed. People are shaking their heads, but it doesn't seem to make much sense to me for me as a doctor to figure out what the insurers are offering me for me to find out what others are willing to get paid, particularly if you're telling me that nobody really knows what they're being paid in the market. I mean, it --

UNIDENTIFIED SPEAKER: There's a 40 percent error rate on those EOBs just for starters, and that's published. So, how can you come up to what you're really getting paid unless, as Bob says, you put resources into it, which are a cost, which increase the costs, simply because we don't get consistency of information from our market?

MR. LEIBENLUFT: Well, I guess I don't understand how everyone's filling out these forms, this survey that's going to be sent around. Is someone

going to help them analyze their EOBs in each doctor's office?

UNIDENTIFIED SPEAKER: No, you take a small population like Dayton, like Bob's group is, and you put the resources behind validating and quantifying and doing it in an organized, structured way with the approval of the FTC. Otherwise, you can't even do that, and that's what's so hard. You can come up with a range, but that range can be impacted by the payer saying, every month, I'm amending the reimbursement to you, and the only way that you cannot go along with that is if you terminate your contract, which if they are a very significant portion of your market, you don't have a choice about it.

UNIDENTIFIED SPEAKER: Take it or leave it.

MR. LEIBENLUFT: I mean, again, I'm not sure how the survey works in Washington, really addressed that issue. I think that's a different issue about people saying they don't know what they're being paid, and I don't see how the survey gets to that issue about knowing what others are being paid.

MR. MATTHEWS: Well, I think your point is that if, you know, you're concerned about an error rate in a survey, I gather, and I don't know how they're going to do this one, but there could be an error rate.

MR. BERLIN: To move the topic somewhat away from I guess one rationale for doing this, and that is giving physicians a better idea of the rates in Dayton and negotiating to -- I believe, Greg, this was your point, that one reason for doing it in Dayton was to make employers educated consumers.

Would it be less restrictive and certainly raise less antitrust concern if the data collection and dissemination, aside from what use is made from it once we have it, but if that is done by some groups other than the competing providers themselves? So, that's sort of a theoretical question I toss out there.

Then, in terms of specifics, I know in this morning's session, Monica Noether mentioned that there is this Medicode data that appears to be collecting some sort of -- and I talked to her after that -- at least, if not data on reimbursement, data on fees charged. Leapfrog I know is at least in the process of collecting data on some sort of quality factors. It's my understanding that the HIAA also has a database, again, that I understand in some way is tied to insurer reimbursement and across insurers. And then you may have folks like Towers Parren or other people sort of in the consulting business practices that, again, I have some understanding have databases.

So, one, I'm wondering whether just as a theoretical matter it wouldn't be a better thing if we could have that data coming from some of these other sources rather than from the competitors, and two, does anybody on the panel have a knowledge of whether these other sources do exist, examples I gave, others, and whether they are -- I'm talking apples and oranges and they're not useful?

MR. BINFORD: Well, from a legal standpoint, the way the venture has been structured is there is a separate entity created separate and apart from the competing physicians, and there will be safeguards built into the system so that, for example, sensitive price information is not shared with physicians, and in fact, I believe much of the data is going to be collected by a contracted third party.

Is that correct, Bob?

MR. MATTHEWS: Yeah, and that was part of the discussion with the FTC, that we would either put someone in the management role who had nothing to do with the prices and was out of the market, or we would get a third party in, but we have decided to go that way just because it's that much cleaner.

MR. BERLIN: Um-hum.

MR. MATTHEWS: As to the issues of whether the

-- the roll-up statistics or whatever that you get don't tend to be very helpful, they are often inaccurate. They have two or three-year lags in them. They lump things up in ways -- they are not very practical. They give you sort of a ballpark picture, but in our particular case, for our purposes, we were trying to get as precise as possible. We want to go to employers and be as precise as possible, not, you know, sort of general.

MR. BERLIN: Um-hum, um-hum.

MR. MATTHEWS: Which is part of my push back to Roxane and Bob earlier about, well, can't you just say that in general this is what's going on? Well, yeah, but in general, who did it or who is doing it today in specific?

I have a question, if it's okay, on the other side, and this is a naive question, and it goes against the Washington letter and the discussion we've been having about that letter, and that is, I'm often told, whether it's right or wrong or I'm being misled or not, by insurers that we know about all these things.

There's a process called subrogation. A number of patients in any given market either have -- you know, the husband and wife both had insurance or there's a secondary insurance of some sort or -- and

so, in the course of processing these claims and sorting out who owes how much, they figure out what other parties are paying upstream, and they gather data, and they tell me, now, what is so and so paying? And I say, well, you know, I'm really not going to tell you that. Well, we know anyway.

So, you know, on the one hand, in this context, the Washington letter is being criticized by Bob and others because, gee, why would this doctor -- but it's legitimate, and in the normal course of business that insurers are sort of trending and watching each other with respect to these, and I have to tell you, after we pointed out to one carrier that they were paying significantly lower than another a couple of years ago, they trued up to within a penny. Now, that could have been random, but I don't think so.

So, I'm going to guess that there are more -- from the doctor side, the carriers tend to have size, and the -- now they have more data, and this Washington letter I think has to be put in juxtaposition to that advantage, and I would throw that out for -- as a practical thing. It's not a -- you guys can hit the law around for me, but that's the practical side. It doesn't feel like an equal fight to me.

MR. BERLIN: Well, actually, both the Washington State and Dayton letters mention the possibility of this facilitating collusion at the payer level. To what extent was that a concern of yours in making the request or is it now ongoing in doing the survey? The letter seemed to answer it, well, if that were really a problem in this market, you wouldn't be asking to do this, since it's a provider-run survey, so --

MR. MATTHEWS: Well, my point -- I guess it's my counter to Bob and to the argument that this letter is disfavorable to the payer side and gives too much power to the doctor side, and my argument is, well, the flip side of it is on a practical -- that the payer has got at least that much and more.

MS. BUSEY: Yes, but actually, understand that my comment about the aggregation would take care of that problem, too. If you have specific insurer information, then you're more likely to have collusion among the insurers, because it's very specific, and so they can say --

MR. MATTHEWS: I see what you mean, yeah.

MS. BUSEY: -- okay, but if it's aggregated, again, they set some information, maybe some information they already have, but the aggregation

takes care of the problem from the insurer side. I mean, to the -- so, I'm not really -- I wasn't really commenting on whether it favored the doctors or favored the physicians. All I was saying is if it is really less restrictive, it takes care of both sides.

MR. MATTHEWS: And I think for us, that's a tactical question. If you know things, when do you -- what do you choose to say? And I think we have to be very careful legally and tactically. We don't want to rush out and produce a ream of data that gives these two large carriers a benefit that they don't already have, because we're not seeing the score as even as it is.

MS. BUSEY: Well, the letter is different, and the Dayton kind of said that they thought the market was concentrated from the insurer side, because you keep saying there are two and they have 90 percent of the market, and obviously --

MR. MATTHEWS: That's pretty common.

MS. BUSEY: -- markets are difficult to define, but let's just take it at face value that you're right and they have a large market share. You know, again, the case law coming not in the health care area but just coming generally is you generally don't exchange information, certainly not specific

information, in markets that are concentrated. So, you're basically -- the antitrust concern would be greater in the Dayton insurer market than in anything else.

In the Washington letter, it's not clear. It's very clearly stated that the physicians are unconcentrated, and Bob raised some questions about that, but there isn't really much of a -- there's a footnote, but there isn't much of a discussion in terms of what the insurer market is in Washington. But it could also be concentrated, it's possible, in which case it seems to me you have as much of a concern as to insurer collaboration as you would have to, you know, any usage -- maybe more concern than you would have for the providers.

MR. BINFORD: And Bill, in specific answer to your question, that the issue of the collusion by the payers came up in the course of our discussions with Judy, with the FTC, and we considered that, and I think just the business decision was made we recognized the risk and were willing to take it.

MR. LEIBENLUFT: Yeah, and to clarify, I'm not saying here that physicians shouldn't have information and health plans should or vice versa. What I'm suggesting here, I think information is very important

for markets to work, and all I'm saying is that when we give the green light about information sharing, we should look about whether the rationale for it makes sense, whether there are less restrictive alternatives, what are the procompetitive implications that they hold up, and does the information exchanged really address what the goals are that are being set forth, and so that was my criticism of the Washington State Medical Association letter.

MS. BOORSTEIN: Let me just ask a question, and I guess this is kind of a general question, which is I mean that you stated that you're having trouble with recruiting, that physicians are leaving, and so you're getting this survey to increase payments to physicians, which sounds like a price increase. So, then, why isn't that something that an antitrust agency should be concerned about if the ultimate goal is to raise prices?

MR. MATTHEWS: Well, look at it from two perspectives. If you raise prices for endocrinology, I would argue you could take your PMPM medical cost of $195 and reduce it, those total costs.

In other words, there are ways to allocate, and I've had personally, working on the health plan side mostly, I've had experience in working with doctors to

reduce the total cost of health care, significantly reduce the total cost of health care, but it's allocating those resources correctly, and it's -- you know, so -- now, what I'm saying, also, is that, okay, we're saving money in Dayton, Ohio by paying certain doctors a substantially lower amount than Medicare, which is not common in the rest of the country. There are a few places, but it's not common.

Now, my group is spending $150,000 to $200,000 to replace doctors who move out of the market, money that we're not spending on Six Sigma, that we're not spending on our new computer system, that we're not spending on things that could really make the system perform well. Now, I would argue that if we were all here trying to move up from the mid-grade Lexus to the upper-grade Lexus, that is a pure price fix, you know, but we're trying to say that when you make it difficult or near impossible for us to invest the money we need to to meet the kind of quality, it's very well known that the information technologies that are largely deployed in the physician side of health care are one step off vacuum tubes, and you know, one of the reasons is that doctors didn't think about their businesses in business ways, they didn't invest capital, and now that they are, you bring them down to a place that's 20

percent below the rest of the country, and they say they can't, and that, I believe, is driving that $195.

We have enormous problems in health care, and I'm going to tell you that taking down rheumatology, endocrinology and primary care is probably driving that up, not down. There are apparently some people from medical groups in the audience.

MS. BOORSTEIN: And just to follow up, what is it about Dayton? Why are payments so much lower in Dayton than, let's say, Indianapolis?

MR. MATTHEWS: I have studied this pretty extensively. A couple of reasons, and I can give you the 30-second answer or I can give you the minute and 30-second answer, but before I was involved in practice operations, I was a consultant, and I did work in Indi, I was in Houston and Chicago, San Francisco and all sorts of places.

Couple of things. Southwest Ohio, Cincinnati and Dayton, are more or less treated the same by most of the payers, and they have been on the cover of the American Medical Association as a place you don't want to go, and when I call up recruiting, they say, we can't go there, literally. People who grew up in our town moved, won't come back, and some of them moved to Indi and Florida and other places, North Carolina.

We have lost doctors to many exciting places. The employer community is in -- in Cincinnati and Dayton is a lot more organized. Cincinnati has Procter & Gamble and General Electric, Aircraft Engines. They pushed managed care earlier and faster. The same in Dayton. Indi is a lot of small businesses. No one is really pushing. The doctors in Cincinnati and to a very significant extent in Dayton were stupid. They stayed, and they didn't aggregate.

When hospitals aggregated, the insurance companies aggregated, and the doctors are a flotilla of dinghies, and they got creamed, and you know, when I started with PriMed, they were at 21 percent below Medicare. You can't run a group at 21 percent. They knew they were hurting. They were at the brink of bankruptcy, and they couldn't figure out why. And we looked at the EOBs and said, well, 79 percent of Medicare could be a clue, and so by not aggregating, whereas in Indianapolis, the hospitals bought them all and then told the large -- the insurance companies, you've got to have us, and we own all those docs, and we'll just stay here, you know? So, there's -- that's part of it.

And so a combination of not watching the store, not learning that this is turning from a profession to

a business and being in a market where employers were very aggressive has been unbelievably costly. And I want to say it's a lot harder to fight up from the basement than it is to go from the top to the bottom.

MR. BERLIN: It seems in these discussions that the potential anticompetitive effect and the claimed justification -- because again, we're dealing with two prospective things here, not conduct that actually happened -- is really pretty close, that the gulf is pretty narrow here. You know, we're talking about being better able to share costs, fee information, share fee schedules, whatnot. So, we really are talking about something that could cut either way.

So, it seems the real key in the analysis is focusing on the next step, and then how is that information utilized. Has there been enough time -- it sounds like probably not in Dayton, and I don't know if anyone here knows about what's going on in the Washington market, but has there been enough time in either place to see whether we're achieving the efficiencies or trending towards perhaps collusion?

And again, maybe you could just give us a little bit of an update on exactly where you are in the process of implementing this plan.

MR. MATTHEWS: We are creating a not-for-profit

entity aboard a physicians -- and actually community leaders, we wanted it to be both physician and non-physician, has been -- or the final people are being recruited. We formed up questionnaires and engaged people to go out -- the data has not really been analyzed at this point, so I -- I think it -- just the fact that we took the step seems to have had some solicitous benefit. I mean, I think that we made some pretty strong statements to the two big carriers. We're going to try to prove that you're hurting this town and your patients, and they have shown some more -- I mean, before, they were like, tough, that's -- life is terrible. Now they're a little more concerned about some of our arguments.

MR. BINFORD: From a legal standpoint, though, the entity has actually not been formed at this point, so we're really a long way from sharing information.

MR. BERLIN: Sure, and Bob, any rumors from Washington that you know about?

MR. LEIBENLUFT: No, I tried to find out, and somebody from -- on the ground there couldn't tell me -- oh, I don't know if somebody knows here.

UNIDENTIFIED SPEAKER: We actually heard from Washington State Medical Association, that they are not moving forward because of problems their State Attorney

General was indicating that there were -- it was not comfortable with it, so that's -- and I think he will probably submit a letter at some point in the process or -- it's pretty much not a go.

MR. BERLIN: I'm glad we didn't know or we wouldn't have had a session.

MR. LEIBENLUFT: Should have invited the State.

MR. BERLIN: Exactly, could have had two panels.

UNIDENTIFIED SPEAKER: We just found out on Friday, so...

MR. BERLIN: A somewhat more technical question for you, Roxane, and that is do you have a reaction or amplification on Bob Leibenluft's comment that the end result, where we came out, where the Division came out in the Washington State business review letter is inconsistent with some of the other opinions that have been issued regarding the messenger or messenger model's ability to negotiate? I think in particular you pointed to the opt-in and opt-out starting price point.

MS. BUSEY: Bob, do you want to restate what you said?

MR. LEIBENLUFT: Well, I don't want to overstate it. What I'm saying is the same concerns

which as I understand it drive where the Division are on opt-in and opt-out on messenger models would seem to also caution about approving something where you'd basically be allowing physicians to collectively disseminate information about an average amount that they've been accepting. It's not exactly analogous, but it struck me as there's some tension there about being concerned about it in one respect and not on the other.

MS. BUSEY: But your focus was on the average, is that what your concern was?

MR. LEIBENLUFT: The focus being on letting a number being out there about what physicians are willing to accept, and that's the average.

MS. BUSEY: That's the average.

MR. LEIBENLUFT: So, for a particular payer.

MS. BUSEY: Okay, my reaction to that is I think that the average is probably consistent with the policy statements, but I do think historically a range was viewed as a more procompetitive indicator. Average tends to suggest a price point, and so if you leave an average price out there, there might be more likelihood of collusion around that price point.

The same thing with a messenger. I mean, it seems to me -- I mean, again, I'm not sure we're going

with the messenger. A messenger who gives a range either to a payer or to, you know, aggregated physicians that are in the group seems to be triggering less of a concern than an average, but that's -- and it's actually -- you know, that's kind of an old -- an old view, and I don't really -- I mean, I think it makes some sense.

I've also seen it done with a high, low and an average, which is interesting because even though it gives you the same price point as the average, and maybe that's useful information, it also gives you the range. So, maybe the best thing to do is that kind of -- I'm not an economist, so I think an economist might be able to comment on this more than I could.

MR. BERLIN: Any comments or questions?

MS. BOORSTEIN: Are there any questions you want to ask or --

MR. BINFORD: No, I think we have discussed it, and we're on the record, and again, I appreciate the opportunity for being here.

MR. BERLIN: We appreciate it. Any other comments or questions by any of the panelists? Any stone we have left unturned on this topic?

Okay. Well, then, two announcements before we adjourn here. One is we will be reconvening tomorrow

morning at 9:15 for the physician IPAs, patterns and benefits of integration session, and two, somebody's keys were found in the lobby. So, if these look like your keys, if you don't have them, then --

MS. BOORSTEIN: That's the Washington --

MR. BERLIN: There's AMA on it, so there you go.

UNIDENTIFIED SPEAKER: They're mine.

MR. BERLIN: Okay, there you go. So, we thank our panelists very much and thank our audience.

(Whereupon, at 4:20 p.m., the hearing was adjourned.)

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

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE WORKSHOP

DATE: SEPTEMBER 24, 2003

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

DATED: 10/8/03

SUSANNE BERGLING, RMR

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

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

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