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I N D E X

SPEAKER:	PAGE:
Mr. Dick	3
Mr. Schwartz	7
Mr. Frech	22
Mr. Miles	32
Ms. Kanwit	45
Mr. McCarthy	59
Mr. Hall	73
Mr. Mansfield	80
Ms. Allen	99
Mr. Foreman	111

P R O C E E D I N G S

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MR. DICK: Welcome and good morning to the joint Department of Justice/FTC hearings on health care and health issues. This is the panel on Competitive Effects in Monopsony and my name is Andrew Dick, I'm the Acting Chief of the Competition Policy Section at the Department of Justice, and my co-moderator is David Hyman, who's on the faculty at the University of Maryland. He is also Special Counsel at the Federal Trade Commission.

Our panel today, as you can see, is quite a large group of experts on the issue of monopsony and health care, more generally, and it includes economists, attorneys, as well as a diverse group of market or industry participants. And, so, I'm looking forward to and I think we can expect a good exchange of diverse marketplace and antitrust perspectives on the issues in front of us today.

For the antitrust agencies, for quite a long time, the exercise of monopsony power was thought to be relatively rare -- or at least relative to antitrust's more traditional focus, which has been on market power or monopoly power, which is exercised sometimes by firms when they're selling for goods of services.

The question of monopsony power is simply the mirror image of monopoly power, but it's applied to the purchasing of those same goods or services.

To say it's received relatively little attention in recent times in antitrust circles, and one reason for that is perhaps -- at least from the economics perspective -- that the textbook economic example of monopsony power, which is perhaps say the company mining town or the company textile town in which everybody in the town worked for the one firm that was located there -- was thought to have very little relevance in the real world, outside of a few isolated locales.

Roughly four years ago, though, monopsony certainly came to the forefront in antitrust circles when the Department of Justice challenged two proposed mergers. The first was Cargill's proposed acquisition of some assets owned by Continental that were involved in the trading of grain. And the second, which is probably much more familiar to this audience, was Aetna's proposed acquisition of the Health Insurance Division of Prudential.

In both of those proposed acquisitions, the Division alleged that the acquisitions would allow the merged companies to anti-competitively influence the price that they paid for key inputs.

In the Continental Cargo case, it was the price that grain elevators are going to be paying the farmers for their inputs, for the grain. Obviously, in the Aetna/Prudential case, the concern that was articulated was that there could be monopsonization over the fees paid to physicians.

In both cases, the Department, as a result of its concerns, sought and obtained asset divestitures that were believed to be sufficient to allay those concerns about the exercise of monopsony power.

But why have antitrust enforcers generally believed the monopsony power is a less prevalent concern in practice that perhaps, say, the exercise of market power or monopoly power among sellers? Well, one of the explanations that's been offered is that there are relatively few markets that are characterized by a high degree of concentration among buyers.

The view is that for most products or services they are going to have more than one use and, typically, the producers are going to be purchasing a broad array of inputs. So, any given input is probably not going to account for very much of their total input purchases or their total cost of doing business. So, the result is, we expect that we are not going to see a consolidation or a concentration of buying power in those markets.

And that general observation is probably true, but it doesn't always necessarily reflect or describe some health care markets. Or, at least, that's the belief that perhaps we're here to test today.

In some instances, providers of medical care may face a relatively confined set of prospective buyers for their goods and services, and if that's the situation, then we may be more likely to hear about concerns relating to the exercise of monopsony power.

Of course, at the same time, perhaps in those settings, we're also more likely to hear counter-claims of enhanced efficiencies that could stem from large scale purchasing. And as I'm sure many of the panelists today are going to help point out, it's obviously critical to reliably distinguish between anti-competitive versus efficient or pro-competitive consolidations among major purchasers.

So, the questions that chiefly concern antitrust enforcement Agencies are what are the competitive effects of monopsony power and how can we identify mergers or specific business practices that create or augment that monopsony power without, at the same time, sacrificing possible efficiencies that could arise from that consolidation among buyers?

Those are two of the topics that, I think,

you're going to be enjoying in today's session. To help talk about those and some other related topics, as I say, we've invited a fairly diverse group of economists, attorneys and industry participants who bring direct experience in thinking about these questions.

The format for today is that we're going to have five speakers start off, each speaking for about 15 minutes. We'll then have a break for about 15 minutes, then the next set of panelists, four speakers, each, again, talking for about 15 minutes. We'll then have another break and come back for a short roundtable discussion. So, we've got a lot to get through, obviously, but I hope we'll keep it exciting for you and in terms of timing, I think we can anticipate that we should be wrapped up just before 1:00 this afternoon.

So, without any further ado, let me introduce the first panelist, who's on the far end of the panel, Marius Schwartz. Marius is a Professor of Economics at Georgetown University, and before returning to academia, he served in the Antitrust Division as the first Economics Director of Enforcement and, subsequently, as the Deputy Assistant Attorney General for Economics.

Marius?

MR. SCHWARTZ: Well, you set a high standard

when you said you wanted to keep this exciting. I don't know if we can, but hopefully informative, at least.

The disclaimer is I'm not a health care specialist, others in this room know a lot more about health care than I do and I look forward to learning from them.

My involvement in health care consists mainly of having overseen the Division's economic analysis of the Aetna/Prudential merger; especially the monopsony side of that case -- the buyer power side.

As Andrew mentioned, at about the same time, we brought a second and quite rare case; namely, Cargo Continental. And, so, what I said I would do today is, first, some brief general remarks reminding us why monopsony or buyer power is, in fact, a legitimate concern for antitrust. And, then, secondly, talk about the Division's economic analysis of the monopsony issues in Aetna and, hopefully, in the process touch upon some of the questions that have been posed with the panel -- not all, but at least some.

So, let me start with a reminder of why monopsony is an antitrust concern. We're more familiar with monopoly, which is market power by a seller vis-a-vis consumers. But monopsony is the flip side; it's market power by a buyer against suppliers.

At that level it seems obvious, and yet when you complain that market power can reduce price and you tell people that that's a bad thing, they say, well, how can a lower price for supplies be a bad thing? Don't we like low prices? And the answer is, well, it depends on why we got the low prices.

If, for example, a merger enables the now bigger buyer to get a lower price because of efficiencies, for example, it buys in bulk, and that saves resources, and that's what enables a lower wholesale price, then that's a good thing. That is likely to also increase the amount of the input that's purchased and, therefore, is a good thing for overall economic performance.

On the other hand, if the low price is the result of buyer power, then the opposite is likely to happen. What gives you now the lower price is the buyer's willingness to reduce the amount that he buys for the purpose of driving down the price.

So, in both cases, there's one thing in common, which is the lower price. But with respect to how much of the input is being supplied, the implications are opposite. In the efficiencies case, the input utilization expands; in the monopsony case, it contracts.

And in that second case, when the input

utilization contracts, what that means is that if you calculate the gains to the big buyer from the price reduction, that's going to be a smaller number than the losses to the suppliers. The reason for that divergence is that an overall loss from the reduction in quantity or what economists call a welfare loss or a dead-weight loss.

So, the buyer has gained less than the sellers collectively have lost. So, in economics jargon, overall welfare has declined.

That right there would be reason enough for public policy to oppose this kind of behavior, whether or not there was some additional impact on the consumers of the final product.

And I'm going to turn to this issue next. Is there, what if any, effect on the consumers? But even if there's none, I would say you can stop right here and you've got the reduction in overall welfare.

What, however, is likely to be the effect on consumers? And, again, the loose intuition might be, if a lower price is being paid for the input, shouldn't that somehow filter down the chain to reduce price that consumers pay for the final product?

And the answer is, no. If the price reduction is because of monopsony, then bear in mind what is

happening. The price reduction is the result of a lower quantity of the input being purchased by that firm. Lower input purchased means that firm will also be supplying less output or same output with a lower quality. Any of these effects are going to be bad news, not good news for consumers.

Now, there's one exception to that, which is the case where consumers are unaffected. They don't gain, but they don't lose either.

And that's the case in Cargo/Continental -- where the example, I think, makes the point most cleanly -- Cargo and Continental bought grain in local markets and we thought they had a fair bit of market power over those grain producers or the grain suppliers.

On the other hand, they sold the grain in world markets. On that side, on the selling side, they were facing competition from a whole host of other grain sellers.

So, it made a fair bit of sense to think that they had, perhaps, considerable market power over the farmers and other grain suppliers, but not -- or maybe no market power -- on the selling side.

So, even if -- and this is a key factor -- the geographic size of the two markets are quite different, the input market is much smaller, geographically, than is

the output market. And, so, in Cargo/Continental, even Cargo -- even post-merger -- would have monopsony power on the input side but lack any kind of market power on the output side, conceptually.

What that means is that even if they cut back the quantity of grain that they buy from farmers and in the process impose a loss on farmers and create the welfare loss we discussed, there may still be no impact on consumers because consumers can simply -- whatever output Cargo and Continental reduces, they can make that up quite easily from other sources.

So, conceptually, it's possible to have monopsony power with no market power on the sell side, as in the Cargo case. Whether that's a likely event in health care, that seems to be much less likely to me, because in health care I would think that the relative sizes of the geographic markets for physician services and for HMO-type services that are being sold by folks like Aetna, would be more or less similar. And, so, it's hard for me to think of a situation where you would have monopsony power and yet zero market power on the sell side. But, I want to be agnostic on that.

Now, next quick question: Antitrust and monopsony. So, having told you that the present price, because of market power, is a bad thing, you might expect

that, oh, then, antitrust should go after all of those instances where big buyers depress prices. And, somewhat surprisingly, we don't. Typically, antitrust does not go after the exercise of market power. In the case of monopoly, we typically don't control the prices a monopolist sets the consumers.

Similarly, in the case of monopsony, we don't, typically, get into the details of the prices that the buyer pays the suppliers. One reason we don't do that, is that this kind of regulation of the detailed pricing and contract terms of firms is quite costly and it's something we typically don't do except in regulated industries, with a specialized agency.

There's another reason why we don't do it, which is if the market power is acquired legitimately, the term is, "through superior foresight and industry," then you want to give people an incentive to acquire that kind of market power. And that incentive comes in the form of getting a return from it in either on the buy side or the sell side.

So, many of the practices I'm sure we'll talk about later on today -- unfair contract terms, et cetera, et cetera -- are typically things that antitrust authorities are not going to be the address to turn to.

Antitrust does, however, focus on acquiring or

maintaining market power through illegitimate means. So, what we try to do is protect the competitive process in the hopes that if you do that then the competition will take care of the prices and other contract terms.

And, so, what antitrust focuses on is unfair practices or restrictive practices, like market division or mergers. And the merger example is the one that we're going to talk about from the Aetna/Prudential case.

Let me use this place to just hit on two more questions that have been posed to the panel, which is, suppose that we believe that the merger will, in fact, increase market power, increase monopsony power, in our context? And, therefore, we expect it to lower prices. Do we then further need to show that the price will be reduced below what would be the competitive level? Or can we just stop there?

And, I guess, my reaction would be that we should bring about the same presumptions that we do when we analyze a sell-side merger. If you have a merger between two sellers, and we show that that merger is likely to increase their market power as sellers and, therefore, raise price, we typically presume that that's a bad thing. We don't say, oh, now how do we know that that price increase still doesn't get us to the competitive level? How do we know the price wasn't

initially too low? We typically presume that.

Now, let's say that same kind of presumption is appropriate when we do monopsony mergers. Now, if this issue is closely related to us, another question that was posed, which is one about countervailing power in a situation where maybe a merger increases buyer power but at the same time there already is pre-existing seller power, how do we know we're not making the world better off as opposed to worse off?

And the answer is, in general, we don't know. And, perhaps, parties could come in on a case-by-case basis and try to say, look, this really is different, but the general position in antitrust is to say, what we want to do is preserve competition at both levels -- try to make sure the sell side is competitive and the buy side is competitive.

So, rather than get into a game where we're going to allow this increase in this consolidation because it upsets that consolidation, we're rather stop them all. That's the philosophy.

So, let me now turn briefly to the Aetna/ Prudential merger. There were two central facts, as I see them, that in the Division's analysis of the merged firm's market power over physicians, and these two factors were: (1) The ability to engage in price

discrimination, and let me explain that briefly.

There was a lot of evidence that Aetna and other payors did not set their prices to physicians uniformly on a marketwide basis, but, rather, negotiated prices separately with individual physicians or individual physician groups.

So, I'm going to call that price discrimination. Prices are not set uniformly marketwide, but are negotiated separately.

Well, what that means is that if post-merger there are certain identifiable physicians or groups of physicians that are relatively more dependent on Aetna/Prudential, the merged company would have the ability to impose a selectively lower price on them, even if it could not impose such a low price marketwide.

The second point is that the ability to impose such a price reduction is going to depend on how big a loss a physician takes if he rejects the merged company's offer and simply walks away? Just say no.

The bigger is the loss the physician would take, the more would be the ability of Aetna to get away with a price reduction.

So, there is reason to believe -- I think pretty good reason to believe -- that this loss that a physician would incur if he dropped Aetna and tried to

replace the patients that he previously was getting from Aetna -- I'm going to call this loss switching cost -- and try to find a new source of patients -- switching cost -- there is reason to believe that switching cost was substantial, and those reasons come from two factors,

One, unlike a physical commodity, a physician's time is perishable, which means if you lost a patient and you didn't provide your services that day, that time is irrecoverably gone.

The second point is that, in fact, it is quite difficult to replace patients that you've lost at a very fast rate. And there's a whole bunch of reasons for that, which, for lack of time, I'm not going to get into, but if there is time, I'll come back to.

So, if you think that the merger increases Aetna's market share, whatever that means -- I'm going to come back to that -- you might think it would give it increased leverage to impose a price reduction on the physicians, because if the physician says, no, he now takes a bigger hit than before.

So, you say, well, what's market share? Well, there are at least two market shares that we thought were relevant. The first and most obvious one is the merged company's market share of patients -- or, if you like, patient dollars -- regionwide. Let's say their share in

Dallas or in the Houston markets -- and I'm going to call that the locality-wide share.

What does that matter? Well, let's do a specific example. Suppose that initially their shares were 15 percent each. Now, they combine to get 30 percent. This is "they" being Aetna and Prudential. That leaves a pool of 70 percent non-Aetna patients.

Now, think about the merged company negotiating with a physician. If a physician now turns down Aetna and is terminated and he needs to replace a patient, the pool from which he can seek replacement patients is now 70 percent of the market. Before the merger, if that same physician was negotiating with Aetna alone, the pool from which he could get replacement would have been 85 percent, because it would have included Prudential.

So, what the merger has done is reduce the available pool from which the physician can seek replacement patients, if he gets terminated by Aetna. What that means is that for every patient that he needs to replace, that's going to happen at a slower rate, which means that your cost per patient -- not just total dollars -- but per patient -- the replacement cost per patient will be higher if you get terminated by Aetna/Prudential post-merger than if you were terminated by either of them alone, pre-merger. And that's one

sense in which the merger provides increased leverage.

The second and related point that also goes toward increase in leverage pertains to the second market share that I mentioned or that I alluded to. The second market share is the merged company's share of that physician's business. So, my first market share was their share locality-wide; the second market share is the share of that particular physician's business. And the two, of course, can differ. The merged company may have 30 percent locality-wide, but 60 percent of some physicians; 10 percent of others, et cetera.

So, why does that matter? The bigger is the -- and this matters only because there are switching costs. If physicians could costlessly get patients from another payer, then it really wouldn't matter who it was getting its patients from in the first place. All that matters is locality-wide. But given switching costs, this thing does matter.

So, now, the bigger is Aetna/Prudential's market share of a particular physician, the more patients that physician will have to replace if he loses the relationship. Fine. Obviously, that's going to mean a bigger total cost. But, more importantly, it's also going to mean a higher cost per patient to replace, just like it did in the first argument, that's going to show

up again. And I'll explain it in a second.

So, the claim here is if before Aetna had 15 percent of your business and Prudential had 15 percent and you were terminated by Aetna and you had to replace 15 percent of your patients, the claim is that replacing -- whereas post-merger you were terminated by both -- you need to replace 30 percent -- the claim is that your loss from replacing 30 is more than twice your loss from having to replace 15. That's the claim.

So, again, assuming you believe that that's true, the merger now increases the merged firm's leverage over the physicians and enables them to drop price and the question is, why should you believe that?

Well, let me just give you a simple example, just to fix ideas. Suppose that the replacement patients -- potential replacement patients arrive at your door at some fixed rate. This is highly stylized, but I get the idea -- like people moving into town -- new people moving into town looking for a physician. Suppose they come at the rate of one a day. Suppose that the physician has lost one patient only and suppose that there's a one-day lag until the first patient arrives. Then the loss they have taken is the physicians have lost one patient's day's worth of income.

Now, suppose instead that I had to replace two

patients. During that first-day lag, I've lost two day's worth of patient's income. At the end of the first day, I replaced one patient; on the next day I replaced the second. So, my total lost patient's day's income is three -- two for the first; one for the second. Now, work out per patient, three day's worth divided by two patients is 1.5. In the first example, it is only one.

Now extend this to having to replace three patients. The patient days lost are going to be three, plus two, plus one, which is six; divided by number of patients, which is three; that's two day's worth per patient.

So, in other words, the average lag in replacing patients gets longer the more patients you have to replace, which means that the cost per patient replaced also goes up, the more patients that have to be replaced.

It's a tricky issue, and if these figures have escaped you, they are written up on my speech on the Aetna/Prudential merger, which is on the website.

The bottom line in all this is that we thought that this combination of a reasonable high Aetna/ Prudential share marketwide, coupled with especially high shares for some physicians, along with the kooky fact of price discrimination and switching costs, made it quite

likely that the merger would allow Aetna/Prudential to impose significant price reductions at least on a nontrivial number of physicians, and that was the essence of the case.

Thank you, and I apologize for running a little over.

(Applause.)

MR. DICK: Thank you, Marius. Our second speaker today is Ted Frech. Ted is a Professor of Economics at UC Santa Barbera, and he's also an Adjunct Scholar at the American Enterprise Institute. Ted is written very widely in the fields of both industrial organization and health economics, and most recently has published a book entitled, The Productivity of Health Care and Pharmaceuticals -- an International Comparison.

Ted?

MR. FRECH: Thanks, Andrew. I first thought about this issue -- many people were here yesterday, also -- but I worked on the Cartel case 20 years ago. In Cartel, the competitive effects were fairly simple, really, and involved the use of the rents the Blue Shield Plan got extracted from the physicians to expand traditional, old-fashioned Blue Cross/Blue Shield-type insurance, which in turn made the market less competitive, less efficient, and it was really bad-old-

days type of insurance, and that was really the main competitive effect. It was a pre-managed care story very different than what you'd need to think about today. But, also, very much simpler.

So, what I'm going to do now is get some fairly general thoughts at a little higher level of generality than Marius did on some of these issues, and it's not going to be a complete story by any means.

The first thing I want to talk about is competitive effects versus welfare effects. Is the question here what happens to the welfare of the whole economy -- buyers plus sellers, or consumers plus other people -- or is it only consumers? Lots of time in antitrust there isn't much bite to that question, because the monopoly directly hurts consumers.

Here for monopsony-type issues, particularly in health care, there can be a real bite to it and a real difference in how you come out, because these monopsonistic buyers can easily benefit -- or at least not harm consumers -- while they're hurting sellers.

Now, one model of this is a cartel of consumers. You might imagine consumers just get together as their own buying cartel, buy from physicians. That suggests, in an ideal setting, that the cartel just takes all the rents from the providers and transfers it to

consumers. It could benefit consumers a lot.

In practice, I don't think this is a very good model. The plans compete away lots of their rents rather than really passing them on, and the nonprofit firms, such as the Blues, use their rents for their own purposes, sort of pursuing their own philosophies and so on, which, as I said, the main argument in Cartel.

So, going back to this cartel of consumers model, realistically the harm to sellers outweighs the benefits to consumers. But, still, the consumer welfare approach versus total welfare often gives a different reading.

The second topic I want to talk about is the question, is a lower price necessarily a competitive harm? This is tricky and, I think, Marius' answer was a little too quick, because you have two things going on: You have the buyer's increasing monopsony power, say as a result of a merger or some particular activity; you also have the fact that they're reducing the pre-existing monopoly power of the sellers.

Since competition among sellers in this industry is pretty imperfect, there's still a fair amount of room to improve there, and certain types of insurance can drastically improve that competition -- PPOs and HMOs, particularly. They perform search for consumers

and they provide stronger incentives for choice of the low-priced sellers, once they are found, it can actually have stronger incentives than no insurance.

So, as a result, PPOs and HMOs can improve competition and lower prices and it could be a direct result of a merger, this is a good thing. This is a pro-competitive thing.

The second thing is that health plan pricing is approximately all-or-nothing pricing. I talked about this a little bit yesterday. There's an excellent article about this by Jill Herndon in the Journal of Health Economics in 2002 -- last year, in 2002.

This complicates interpretation of price changes and price differences. So, analytically, monopsony can get care at about the same output but with a lower average price from doing this kind of all-or-nothing pricing.

Another problem is that price can be defined, and is defined, in these markets in all kinds of weird ways, so as a practical matter, coming down a little bit from 20,000 feet, it's really hard to tell if the price has really changed when the whole type of price or the basis of the price changes. We've got a continuum between pure capitation and pure fee for service, and most contracts are somewhere in the middle, with aspects

of both.

Another topic -- historically, Blue Cross/Blue Shield programs were the main suspects. They had the overwhelming shares, they had the obvious market power in selling insurance in most states -- it very much varies by state. Now, this market power that they had, historically, was due to their regulatory and tax advantages, which were for a long time very strong in many places. Those advantages have been weakened over time, but the Blues still are probably the biggest concern.

Monopsony was easier to analyze in the old days when the Blues were almost the only concern and when the Blues had traditional old-fashioned, indemnity-type insurance, and in those situations there clearly was a vicious cycle or vicious circle connecting monopsony in the buying side to monopoly in the selling side -- selling of insurance.

This worked in the following way: A plan would get low prices from sellers and providers, that would lead to some rents, and maybe lower marginal costs -- it depends on your model of how the pricing works, exactly -- but, either way, you would get, at least with nonprofit firms like the Blues, you would get lower premiums, that would lead to higher market shares selling

insurance, which, in turn, increases monopsony power, because the firm has more high percentage of the local customers, it has more monopsony power, leading to lower prices.

And the empirical work from the late 1980s shows this pretty clearly. Some of my work shows that Blue Shield physician discounts were strongly correlated to Blue Shield market shares across states.

Similar work by Feldman and Greenberg and Adamache and Sloan on Blue Cross hospital discounts, showed the same kind of relationship.

It would be very interesting to see a similar analysis in newer time periods and not limited to the Blues. Also, probably, it would be better to get a finer geographic level than States, which is what all this other earlier literature was.

Another question: Do prices have to be driven below the competitive level for it to be a competitive harm or just below some starting level?

Well, here, I think, again, the recognition that there's pre-existing market power by providers is important. And when we keep that in mind for this industry, my answer would be that prices would have to be driven below the competitive level, not just reduced by a merger or some other activity.

Indeed, reducing prices towards the competitive level is one of the general purposes of managed care and one of the -- to the extent it happens -- one of the competitive benefits of managed care and efficient health plans.

Another topic: Does output have to be reduced to have a monopsony problem? Here I would say no, not necessarily. Because of the all-or-nothing nature of the deal, approximately all-or-nothing nature of the pricing, output may not decline. And, in fact, if the main effect of, say, a big merger or something is to reduce pre-existing provider market power, you might simultaneously see monopsony power and output increasing.

Well, related to this idea of reducing output, what about driving producers out of the area? Well, I'd say this is not, actually, a useful diagnostic. We know from the literature that more managed care -- higher market share of managed care -- leads to slower growth in the number of physicians at the MSA level, the city level. You can see this in Scarsa, et al in health services research in 2000.

Some recent work I'm doing with Jim Brether and Lee Mobley shows that this is also true in a cross section at a much finer level of geographic detail. Within California data, if you take as the market the

health facility planning area, which is quite a bit smaller than counties -- there's over 100 of them in California -- you find that where market shares -- I shouldn't say market shares -- the managed care penetration is higher, the number of physicians is lower.

Now, both of these studies have nothing to do with monopsony because they're not measuring the share of any one seller; they're measuring the share of the type of insurance and showing that that affects physician location -- pretty substantially.

Also, using this as a diagnostic in actual antitrust cases, implies a long waiting period -- like years -- to sort of judge what the effect of, say, a merger or some business practice or contracting practice is. It just seems awfully long for antitrust.

Another topic, another question: Can a payor have monopoly power -- I'm sorry -- can a payor have monopsony power without having monopoly power as a seller?

And the answer is, I'm sure, in principal, and the Cargill case sounds like a perfect example. In health care the way that can happen -- and I think the way maybe it does happen, at least on a small scale -- is some of these national PPOs, like First Health is probably the leading company, they put together national

networks which they, then, in effect, rent to other insurers. And their particular focus is to get national accounts. So, they really do have nationwide coverage in their PPO networks.

Well, they might well be, because of the accidents of whose insurance is in some particular town, that they would have monopsony power, say, in some small -- well, not necessarily small -- in some city where they have some really big customer insurers, so they had lots of people, so they would have some monopsony power in that town and they would get better prices there and their negotiators are sensitive to these kinds of things, of course. But their market is really national. And, as Marius was saying, they have a -- they're buying the services in the local market; they may have monopsony here and there, sort of by accident of who their customers are, but they really only sell to nationwide companies. There are not a particular efficient way of dealing with buying health insurance if you only have one plan in one county. So, their customers are all national companies and, also, some of the federal employee plans, which also need to be national.

So, they don't have market power selling their networks or renting their networks, but they would have some monopsony power here and there, just sort of by

accident, and maybe in a fleeting way.

The next topic is: What are the competitive effects or competitive harms given different starting points. And I've touched on this a little bit before, but the issue is, are we starting from something like competition and say a merger or a new practice drives down prices below the competitive level, or are we starting with some market power, so the price is going down to some extent and is probably pro-competitive?

Well, I think, most likely, we're starting in most placed with a fair amount of provider market power and, so, depressing prices, at least some, is probably a good thing.

I would like to say, though, that monopsony is a temptation for really big payors. And if it goes to a real extreme, which I would say it does in some other countries -- Japan and Canada sort of come to mind -- where the government is the buyer and it has clearly depressed prices well below the competitive level and it causes lots of nonprice rationing and changes the whole character of the whole system, this is, you know, a very bad outcome, and they've gone way below the competitive level, I would say.

Let me just conclude: I'd say there are no economic principles here, but in practice, applying kind

of the basic ones to this industry, are tricky, mostly because of the pre-existing market power providers.

So, what you think of activities and mergers and so on, depend on what you think the starting point is. And a kind of classic benchmark starting point in economic theory for analyzing monopsony, most of the time, is competitive equilibrium, partly because it's a fantastic simplification and partly because it fits a lot of industries pretty well.

I think with health care we're in a much more difficult and murkier world where we're starting with some amount of market power on the part of providers, in most cases.

(Applause.)

MR. DICK: Thank you, Ted. Our next speaker is Jeff Miles. Jeff is a principal in the Washington office of the law firm Ober Kahler. He specializes in antitrust and, more particularly, in health care antitrust issues. Before entering private practice, Jeff was the Assistant Attorney General in the Virginia Attorney General's Antitrust Unit and also, before that, was an attorney with the Antitrust Division here in Washington.

Jeff?

MR. MILES: Thank you. Good morning. I appreciate the opportunity to be here. I am not an

economist, so what I have to say may seem somewhat simplistic, and maybe it is, but I'm going to try to go back and provide you with sort of a lawyer's overview and perception on the monopsony issue. I find myself in a position where I represent people on both sides of this issue and, hopefully, that will give me some objectivity in what I'm going to talk to you about today.

If you're not an expert in this area -- and I'm not -- I wanted to mention a few -- three or four resources -- that I find particularly helpful. And I find them helpful because they're pieces of literature that even a lawyer or a business person can understand. They do not involve a large number of equations or econometrics, and if I read very slowly, I can usually follow these.

Two are by people on the panel. Marius Schwartz did a paper for a Northwestern Seminar back in 1999 on the Aetna/Prudential merger. In fact, I read it coming in on Metro this morning. I always read it before I know I'm going to have to address a monopsony issue. I think it's still on DOJ's website. Is that right?

MR. SCHWARTZ: Yes, because I read it, too, this morning.

(Group laughter.)

MR. MILES: All right. But, anyway, I'm

sure -- if it's not on DOJ's website, I'm sure Professor Schwartz can get you a copy, or if he can't, I can. So, be that as it may.

Tom McCarthy did a paper in the ABA Antitrust Section, Health Care Chronicle, back in the summer of 2002, and I think it's the paper you're using at this session, entitled Antitrust Issues Between Payers and Providers, the Monopsony Concern. And I think that's very helpful.

And, then, thirdly, Professor Mark Pauley, in '98, wrote an article in Health Services Research entitled Managed Care, Market Power and Monopsony, which I think is particularly good. It does have a few graphs in it, but I understand those graphs; but, still, there are not many equations.

And, then, Professor Roger Blair, who was on the panel yesterday, has done a good deal of writing on the subject. He has a book on monopsony and, also, he and Jeff Harrison, back in the early '90s, wrote an article entitled Antitrust Policy and Monopsony, and it's in the Cornell Law Review, Volume 76, 1991.

Anyway, these are the resources I go back and try to review so I at least sound like I know what I'm talking about.

I guess I'll start by saying I'm very glad the

agencies are taking a look at the monopsony issue. I think it's an issue that both at the agency level and also at the court level has been overlooked for a number of years. I do think there are some antitrust issues there, what I don't know is how serious those antitrust issues are or how frequently this problem actually arises, but I think it would help if the agencies looked into that particular issue itself.

I assume by now everybody understands what monopsony power is. It is simply the ability of a buyer or a group of buyers acting in concert to decrease the price they pay for an input by restricting the amount of the input they purchase, with the emphasis on the latter part, because the effect is because the buyer restricts the amount of input it purchase. In other words, "low prices" by themselves are not an indication or certainly not proof of monopsony power.

I guess there are probably three classic elements: One is a large market share on the part of the purchasers; number two is an upward sloping or somewhat inelastic supply curve in the input market; and number 3 is either an inability or unwillingness for new purchasers to enter the market or current purchasers to expand the amount of their purchases in the market. These are three characteristics that, I think, are

essential before monopsony power can be present or exercises.

From a legal standpoint, the issue arises in a number of contexts. It arises directly, for example, in buyer price-fixing cases, where purchasers simply agree on the amounts they'll pay their suppliers. Early examples are the Sacony Vacuum Case back around 1941 and the Mandeville Island Farms case around 1947, in effect, naked price-fixing agreements. Although, on the buying side, I'm not sure exactly what a naked price-fixing agreement is as opposed to an ancillary price-fixing agreement, and I'll mention that in just a minute.

Another issue that arises is buyer exchange of price information programs that don't reach the level of an outright price-fixing agreement. You see these, for example, in employer's conducting wage surveys or exchanging information on the wages they pay employers. The leading case is probably Todd v. Exxon Corp., a 2001 Second Circuit opinion, where the major oil companies, the HR people got together, they had very detailed wage surveys, and then got together to discuss the wage information. And the allegation was, under the rule of reason, that this had a stabilizing and decreasing effect on the salaries these companies paid.

Another example is an enforcement action

brought by the Justice Department a number of years ago against hospitals in Utah, where the HR people allegedly were getting together and exchanging wage information regarding nurses' salaries and discussing the amounts that they would pay nurses.

Another area where monopsony issues can arise is in group purchasing arrangements, simply where purchasers get together, through a GPO, and purchase on a collective basis. Statement 7 of the DOJ Antitrust Division Health Care Guidelines discusses this directly.

Group purchasing arrangements, to some extent, have always raised a question in my mind regarding the distinction between a naked buyer price-fixing agreement that supposedly is, per se, illegal, and an ancillary price-fixing agreement that's tested under the rule of reason.

If you look at a lot of group purchasing programs, there's really rather little integration among those purchasers. There is certainly not the degree of integration that the agencies require on the seller's side when physicians, for example, form an IPA. In other words, there are a lot of group purchasing programs in which there are no risk-sharing mechanisms and, certainly, where the group purchasers are not, so-called, clinically integrated.

So, the rules to me seem to be technically the same on the buyer and seller side, but as a practical matter a little bit different.

I'd say the same about a lot of the employer-health care coalitions I see. Very little integration; they really do little more than get together and bargain as a group with providers over the prices they'll pay for the provider services.

So, again, I think, although as a technical matter, the rules are supposed to be symmetrical on the buyer and seller side, as a practical matter, very frequently, they're not.

Mergers: The Aetna/Prudential merger has sort of been beaten to death and probably will be beaten to death a little more among the panel, so I won't say a whole lot about that.

And, then, you have a number of, I guess I would call them Section 2 -- Sherman Section 2 -- monopsonization claims, where, for example, a provider comes in and simply says, I'm really unhappy about the low noncompetitive reimbursement I'm being paid, the payer is a monopsony. And right now there's an interesting case up in the Eastern District of Pennsylvania that's been filed but not decided where a hospital challenged a number of actions a Blue Cross plan

took to allegedly lower reimbursement, claiming that these were exclusionary acts that prevented or drove out other purchasers or prevented other purchasers from coming in the market and, therefore, resulted in monopsonization, assuming there is such a legal violation, and I'll talk about that in a few minutes.

There are some off-shoots that can arise or affect or come about in monopsony cases -- most-favored nations' clauses, for example, implicate or can implicate monopsony concerns. In extremely narrow circumstances, I think all products clauses can implicate monopsony concerns, but I, frankly, think the circumstances under which that is the case are so unusual that it's probably not much of an antitrust concern.

And, then, finally, different types of exclusive arrangements involving payers with monopsony power can have some relatively serious foreclosure effects -- and foreclosure, by itself, you know, really is not an antitrust problem unless it gets to the extent that it actually results in a party's being able to exercise market power itself. And there are certain requirements that have to be met before that's the case.

The effects from monopsony power, I think, are a particularly interesting aspect of it -- or trying to access the effects. It's a little more complicated than

market power issues on the buyer side because you really have to analyze, I think, as the speakers have indicated, two markets: you've got an input market and you've got an output market, and you've got to analyze supply and demand considerations in both before you can tell what some of the effects, especially the effects on consumers, might be.

Looking at the input market, that's the situation where payor purchases physician services or hospital services. There are several situations that can arise; one is the bilateral monopoly situation, which has been alluded to; that is, where both the payer and the providers have market power and sort of beat each other over the head to see, frankly, who's got the most negotiating power. I think the economist will tell us from an equilibrium standpoint the result on allocative efficiency in that situation is indeterminate: it's simply a function of who's got more power.

And, then, you have the situation in the input market where the seller market, the physician market, is competitive, the buyer has monopsony power, and that's generally where the antitrust or the efficiency effects or the distributional effects from monopsony power occur.

And, then, you have to look at the output market. The conventional wisdom is even if a purchaser

has monopsony power in an input market -- and this was alluded to before -- if the output market is competitive, then there is not going to be an adverse effect on consumers, although there still may be depending on how you define adverse effects on participants in the input market.

How have courts handled the monopsony issue? Well, I think there are two things to say: Number one, there are very, very few cases that discuss monopsony itself, as opposed to monopoly, in any detail. In fact, the courts tend to confuse the two when they talk about cases that are really monopsony cases.

And, number two, to the extent courts have handled the issue of monopsony, overall I would say, except until very recently, they haven't done a particularly good job. It was alluded before that, I think, that some courts have taken the position that, gee, whiz, monopsony must be good. These lower input prices must be passed on. And, as our economist friends told us before, that ain't necessarily the case.

I guess the classic decision that pretty much holds that is a 1989 Sixth Circuit Decision, the Balmora Cinema case where, I think, the court pretty much screwed up the analysis. So, anyway, the analysis so far hasn't been particularly good.

There also are some courts who have indicated that there's not an antitrust problem or a competitive problem unless there is an effect in the output market. In other words, if the effect is only on the input market, they take the position, so what?

That subject has also been discussed and the more recent cases make it clear that, from a legal standpoint, there doesn't have to be an adverse effect in the output market for there to be a problem with the monopsony itself.

Is there such a thing as a Section 2 monopsonization violation? Section 2, of course, doesn't mention monopsonization, it talks only about monopolization, but I think all of us are pretty clear that, even though as a technical matter Section 2 doesn't mention monopsony, the same rules of the game would apply simply because monopsony is simply monopoly on the flip side of the market.

The elements, I think, of monopsonization are probably symmetrical of those of monopolization. You need, first, to define a relevant market -- and we talked about that yesterday -- you simply flip the analysis around and instead of looking at what the alternative buyers have, as you would in a seller market power case, you look at what the alternative sellers have; you'd have

to prove monopsony power, just like you would have to prove monopoly power in a monopolization case; and, then, I think, you'd have to prove predatory, or what some people call unreasonable exclusionary conduct, to either obtain, maintain or increase that power.

Herein lies an interesting problem when you're counseling providers. Most providers don't understand that monopsony power, by itself, is not unlawful. They don't understand how large Blue Cross plans, or other payors, that they claim have monopsony power, are not violating the antitrust laws.

And, so, you try to explain to them, in a monopolization case, it's simply not unlawful, if you've obtained your monopoly legitimately, to charge the monopoly price. And the same is true on the flip side -- if the monopsony power has been obtained legitimately, the purchasers can pay as low a price as it can get away with. And, as many of you know, there are legions of cases -- well, legions is an overstatement -- but 10 or 12 cases that make this crystal clear. It's just not unlawful to charge a monopsony price.

Now, thinking about what the necessary predatory conduct is is a little more complicated, just like it is in a monopolization case. The First Circuit -- and Professor Frech knows this better than I

do, probably -- has suggested that it is predatory for a monopsonist to pay providers a price below their costs. The Cartel case suggests that; the Ocean State case suggests that. The logic of that absolutely escapes me and, from a practical standpoint, I don't see how you ever implement a standard like that. How in the world is the payer supposed to know what the provider's costs are and whether its payments are below those costs or not? That won't work.

To prove a monopsonization case, you need conduct that excludes alternative purchasers. That's the type of conduct. There are a number of types of conduct that might fit this bill -- the mergers, we talked about that -- a merger of competing purchasers; market allocation agreements among competing purchasers, which is one of the allegations in the Pennsylvania case I mentioned; most favored nations clauses can result in entry barriers, depending on some market characteristics; payer requirements that an employer deal only with it; an exclusive dealing contract; or a quasi-exclusive dealing contract where the payer says, I'll provide coverage only if "X" number of your employees sign up with my plan -- these can have foreclosure effects on other purchasers; these sorts of practices.

And, then, I'll just agree, briefly, with what

the others have said about the question of whether low prices, by themselves, show monopsony power. And the obvious answer is, no. There may be differences in bargaining power and there's nothing the antitrust laws can do about simple differences in bargaining power.

But, to try to distinguish between simply greater bargaining power or monopsony power, I suppose the only way I know how to do it is to look at the effect that the conduct has on the quantity or quality of the input purchased. Otherwise, I would enjoy listening to the economists' view of how you distinguish between, simply, one party having more bargaining power than another and true monopsony power.

(Applause.)

MR. DICK: Thank you very much, Jeff. Our next speaker is Stephanie Kanwit. Stephanie is the General Counsel and Senior Vice President of Public Policy and Research at the American Association of Health Plans, and in that position, Ms. Kanwit leads a team of policy and legal staff that research a broad range of health care issues. Ms. Kanwit previously has been in private practice as well as having served as a Regional Director for the Federal Trade Commission.

MS. KANWIT: Thanks very much, Andrew, and thanks for having me this morning. I really enjoyed the

dissertation by the law professors and Jeff about monopsony power. I was fascinated a few months ago when one of the professors who testified, Jim Blumstein, said that he wasn't sure that health insurers had any kind of monopsony power, because maybe they weren't even buyers; maybe they were sellers of access to patients, and I was fascinated by that. I hope he writes an article at some point about that.

What I'm going to do this morning is show you quick slides, and what they have on them are what I call empirical data -- real world data about what's going on out there. Obviously, the topic of my paper today is the Myth of Monopsony Power, so I'm going to debunk that particular myth and tell you about what I see, which is incredibly vigorous competition.

I also see out there a complete overuse of the term monopsony. Obviously, as we have been talking about the mirror image of monopoly power, to characterize what we, in the health plan industry and the health plan markets think of as one of the most highly competitive markets in the entire country.

I also see the term "market power" being used deductively and misused deductively to come to whatever conclusion a particular thesis wants. And, obviously, there I'm predominantly referring to the American Medical

Association's study of competition in health care markets, which talks about how there is a dominance by a few firms and artificially low prices, and I just don't think it bears any relationship to reality whatever.

What I would like us to do, and I can't do it in all the slides, but I try to do it in outlining my paper, which is outside for anyone who wishes to read it and the accompanying charts, is to be looking at the market in an antitrust sense, which is all methods of health care financing, not just specific health care products or delivery systems, like HMOs or PPOs.

And for an appropriate analysis, I think that the antitrust agencies have to be looking at not the share of a particular doctor's business that a particular insurer represents. I'm always disconcerted when I hear that, you know, Dr. Schmoe, or even 100 or 200 or 500-person doctor group, and they're looking at seeing what percentage of that group's business is with Humana or CIGNA or Aetna or any of the big companies in the industry.

The real issue is: What are antitrust laws supposed to do? I think we've got to look at it in the macro sense. First of all, economic goals, the efficient resource allocation -- you've heard about that this morning -- and conservation of scarce resources. Very,

very important in the health care area.

Secondly, social goals. The dispersal of private power, ensuring the widest possible degree of economic opportunity -- I'm quoting Professor Sullivan there -- through facilitating entry into a given market. So, it's the economic goals and the social goals.

Impossible to concentrate on one particular physician or one particular group. As you many of you know who are antitrust lawyers in the audience, the Supreme Court keeps saying, antitrust is supposed to protect competition, not individual competitors.

All right. So, what do we see out there? What we're supposed to be looking at -- we'll be looking at on my slides -- is the ability of physicians, generally -- and by the way, increasingly larger physician groups, sometimes in coordination with massive, massive hospital systems -- to sell their services to a myriad of buyers. Those buyers include, insurers, employers with self-insure patients -- believe it or not, there are self-paid patients out there still -- as well as publicly funded programs like Medicare and Medicaid -- hundreds of billions of dollars of money in that.

In short, for a health plan to have monopsony power in a given area, an individual physician or group must have no alternative buyer for their services. And

that's an impossibility when, in fact, number one -- and I'll show you slides about this -- physicians, on average, obtain less than half of their practice revenues from managed care contracts -- less than half -- that's from the Center for Studying Health Systems Change from Charles River Associates -- again, in my paper.

And, number two -- and this statistic floored even -- even me, who has been looking at this stuff -- the average physician contracts with about a dozen health care plans, and that number is rising.

Flag number one: All I'm doing is outlining what's in the paper, which is consumers and employers having a number of choices among health care plans and a broad array of options. Again, the bottom line of all of this text here is the vigorous competition out there -- and, by the way, it's getting more and more vigorous, and we can talk about that -- and number two is the enormous increase in the variety of products and options out there; consumers switching from plan to plan; what they call consumer empowerment; consumer-directed health plans; consumers who want -- and when I use the word "consumers," I also mean employers -- who want broader networks, more choice of doctors, more choice of plans, more types of products.

The bullets here talk about eight or more

managed care companies in each of the top 40 MSAs -- and we have some charts on that -- each of the companies offering multiple variations of products. And, then, within those products -- and this is the key fact that often people miss or people I talk to miss -- unlimited offerings. In other words, under ERISA, for example, you can design a benefit plan exactly the way you want it. You can have a Ford Plan, you can have a Cadillac Plan. You can have it include mental health benefits up to $2 million or unlimited benefits. You can have acupuncture, or whatever else you want. I know many of our health plans actually allow, as part of the benefit package, things like acupuncture and even health club memberships, not to mention dental and some of the other alternatives. Bottom line trend to broader networks, more docs and hospitals included -- much wider range of product offerings.

This is a schematic that we pulled out of a book just to show everybody health plan choices. It's by no means complete, but I thought it was interesting. I don't know if you can see it on the screen. Basically, I just wanted to show the enormous number of health plan choices out there. People talk about, you know, health plan products -- they see them in discreet little buckets, but the fact is they are a huge variation,

almost unlimited, except by law and by regulatory authorities; and, even then, it's unlimited.

On the left, we have a whole bucket of HMO products; in the middle PPO products; and on the right other managed care plans. I just want to know in the middle, on the PPO products, for example, they have sponsored by HMO, sponsored by the insurers, sponsored by physicians -- physicians are in this market, heavy-duty -- sponsored by the employer.

Under other managed care plans, as I mentioned, consumer-directed plans are a big deal these days, as are things like MSAs -- as many of you know, Congress is looking quite closely at consumer-directed health plans -- as are many of the larger insurance companies, as well. One note there, the specialty HMOs, way down at the bottom of the page -- and all I mean by that is health care services or subsets or single specialty is what that really means in delivery terms in an HMO model -- dental, vision, rehabilitation services.

This is a slide from AIS, the Atlantic Information Services, showing competing health insurance sellers exist in every major metropolitan area. And I think these numbers are surprising, too. Eleven in Atlanta; 10 in LA -- more detail on this, actually, in every major MSA. In my paper, we have a three-page

summary of what AIS found in the multiple competing department.

Again, multiple coverage models offered by each individual health plan -- 3.7 in Los Angeles; 3.36 in Atlanta -- caveat, again, when they're talking coverage models, they're talking a PPO model, an HMO model. Obviously, within those models, you're talking about a myriad of possible options and choices -- mix and match kind of thing. And, again, the market pressure is out there and you can talk to some of the plan panel here on this very panel, the pressure right now is more -- people want more choices; employers want more choices; they want more open networks; and that particular pressure is being aided and abetted -- just one example -- by the Supreme Court, just a few weeks ago decided, as many lawyers in the audience know, the Any Willing Provider Case, which, basically says, states can pass Any Willing Provider laws, possibly eliminating the option of closed networks; that states can say, a health plan -- for an HMO kind of health plan -- has to let any provider willing to meet the terms and conditions into the particular network.

So, we have both the consumer pressure to open up networks, increase options, increase the numbers of doctors and hospitals -- we also have the legal pressure.

Physicians and other providers have market

power of their own. Again, I talk about this in detail in my paper, but, basically, the concept here is I -- when we look at this data in our office -- and many economists look at it -- don't see dominant buyers of health care services out there holding sellers -- physicians, namely, captive. In fact, as I mentioned before, less than half of the revenue of the average physician practice comes from managed care. The physician self-services to a wide variety of buyers. As I mentioned, Government plans; self-insured TPAs; physicians contracting with enormous variety of health plans -- this is generally, obviously -- there's often contracts and negotiations with large group of hospitals -- hundreds of physicians -- even thousands of physicians; the status of must-have providers and managed networks; the Charles River Associates -- Monica Noether did a very nice paper where she talks about must-have -- we're seeing that more and more -- the specialty hospitals, the specialty physicians, the expert cardiologist, the cancer specialist -- are going to have must-have status; many hospitals have -- and we've talked about this in the past hearings before the FTC and DOJ -- the hospital systems which have must-have status; or the hospital systems which are the only game in town in a particular county; for a particular segment of the

market; e.g., Medicare, where that hospital is the only one that's going to be delivery services to Medicare patients, so that the health plans who are administering the Medicare+ Choice Program need that particular hospital -- very important must-have point. And, last but not least, consolidation, and we've had hearings on that.

So, I won't go into details, but that is still a very serious problem for our health plans in negotiating with -- usually -- hospital systems, but sometimes provider groups as well. The all-or-nothing contracts that terminate instead of negotiating -- they start the bargaining process with a termination; the mandates about using their ancillary facilities -- often physician-owned facilities like radiological services that our health plans must contract with that particular ancillary facility or are not going to be allowed to contract with the hospital system.

Individual physicians normally contract with multiple health plans. Again, this number surprised me -- 12 -- today's it about 13. This isn't a situation where, you know, one health plan has 80 percent of the business with the particular doctor and can tell him or her what to do.

The number of physicians in hospital contracts

and health plan networks is increasing. I mentioned that point. This is a very, very important point. Again, this is because of broader provider networks and more emphasis on PPOs. I have some statistics in my paper that talk about the PPO option out there. About 75 percent of employees today can choose a PPO option. And that's up from 45 percent in 1996. So, in other words, PPO options, where you can go out of network for perhaps an additional co-pay, are very, very popular.

HMO options are becoming less popular; they're going in the opposite direction. And, again, this is because of the emphasis on consumer choice. People are willing to pay -- both employers and consumers -- a little bit more money to get their choice of hospital or choice of doctors.

Last, but not least, entry barriers. This, of course, is the elasticity point that many of us have made on classical monopsony theory. Again, major markets have eight or more competing plans -- the second point is important -- the multitude of small, single-state and regional plans -- not only competing right now, but entering. Lawrence Wu, this week, spoke and talked a little bit about low entry barriers in the health plan area and talked about the low cost of expanding capacity.

I'm always surprised when I see the numbers at

AHP. Some of our members have under 100,000 lives in their particular health care plans. We do not just represent the behemoth of the industry -- the CIGNA, the Aetna, the Humana's -- we also represent very small health plans, in particular, niche markets.

The switching point, which is bullet number 3, that employers and workers exercise sway in choosing the type of health plans, which I've pointed out, as well as switching to those to meet those needs. And, again, I know Lawrence Wu talks about that, in particular. This is part of the structural issues of monopsony; again, the elasticity.

Bullet 4 is about the provider-owned health systems continuing to flourish and take new forms. You cannot, literally, pick up the paper or health care papers without reading about new kinds of provide-owned systems. Just recently, there was an article in BNA, Bureau of National Affairs, about physician home specialty hospitals -- and I know this is growing in many markets in the country -- where physicians are starting up hospitals, for example, to deal only with cardiac care or only for orthopedic care. It's of great concern to Congress, which is going to hold hearings on this, and everyone is quite concerned because of the possibility that it will take business away, obviously, from

community hospitals -- skim the cream and create locations in particular markets.

New models of health care financing emerging; e.g., I point you to consumer-directed health plans, but you can see many more of that out there. By the way, the statistics show that about 1.5 million individuals are in consumer-directed plans. And, as I mentioned, some of the major health insurers are also looking in that area. Congress is helping that out with reforms to the tax code that will make them attractive. So, that's another option.

Last, but not least, self-funding remains an employer option -- that's often forgotten. Fifty percent of Americans are enrolled in self-funded plans, as we speak today -- 50 percent -- with an employer who has enormous flexibility in benefit design.

In conclusion, I hope these slides have shown -- at least, I think they've shown -- that the competition in the market -- and the slides in my paper do the same -- what we're -- my bottom line here is there's absolutely no evidence of health plan monopsony power. In fact, I believe the data show exactly the opposite -- a competitive marketplace; health plans and insurers competing vigorously in terms of price as well as quality; physicians contracting with multiple health

plans; joining larger and larger group practices; engaging in more and more commercial ventures in the health care field, which I think is great for competition; such as the physician-owned hospitals I mentioned.

Also out there, and I mention this in the paper, employers are continuing to shop for the best value. Many speakers on the previous panels have made that point. This is a competitive marketplace and one of the reasons it is is that you have employers -- both large and small -- especially today in an era of double-digit cost increase -- saying, yes, I want quality in my health plan, but I also want cost -- I want to make sure I get the best bang from my buck and from my employees' bucks -- and they're shopping vigorously for health care. We are seeing that in all of our health plans.

Thanks very much.

(Applause.)

MR. DICK: Thank you, Stephanie. Our next speaker -- and, then, after this we'll take a short break and then reconvene for the second set. Our next speaker is Tom McCarthy. Tom is a Senior Vice President at NERA, National Economic Research Associates, and Tom heads up NERA's Health Care Practice, and in that capacity he has worked on numerous health care industry mergers involving

hospitals, hospitals systems, health insurance and physician groups, and, so, he brings a wide range of experience.

MR. MCCARTHY: Thank you, Andrew. I'm anxious to get to the discussion section, because there have been several things raised that I'm very tempted to comment on now. There's always when you're the fifth speaker or later, there's always the temptation to throw it all away and just start engaging in what's been raised. But I think we'll get to it in the comment period.

During yesterday's session, I spent some time describing why I believe that the textbook monopsony case didn't apply to health care, and, you know, it's prediction of misallocated resources. Some of that I will want to come back to in the comment period, particularly I want to talk with Marius about some of the assumption in his switching model. It's a very clever switching model -- a very nice, simple economic theory that has a lot of meaning, but I want to talk about some of the underlying assumptions as to why the switching isn't so difficult.

Now, today what I want to do is cover three topics. The first would be I want to suggest that the equilibrium condition in the input market that you start with matters a lot to the analysis, and Ted Frech already

touched on this, so I can probably go through that a little quicker.

Second, I want to offer a list of various indicia of monopsony. This is going to be sort of the tangible list; this is not the theoretical list. Obviously, I'd love to do statistical studies about the elasticity of supply in the input market, which is sort of the number one thing, but I just want to give everyone a touchstone of the kinds of factors that you would expect to see if you had a monopsony.

The third thing I want to do is give you -- I guess following Stephanie's lead now -- I want to give you some real-world data. It's not at all dispositive, but it has to do with things going on in markets where monopsony lawsuits have been filed.

Let me start with defining monopsony power as I define it for health care. It's the ability of a firm to profitably set marketwide reimbursement rates -- marketwide being important there -- below competitive levels, on a sustained basis.

Yesterday we talked a bit about what that sustained basis would mean, and we can come to that a little more, but, obviously, any market adjusts. If there's a transition in a market, resources move in and out, and I think that that's really one of the keys in

monopsony -- understanding what the adjustment possibilities are.

Following Ted a little bit here, let me talk about different possible input market conditions. Depending upon what the input market looks like, you will have different implications for either the formation of a monopsony or, possibly, misinterpreting that monopsony exists.

One possibility is a situation which I'll call excess demand or what's been also labeled a bilateral monopoly situation. Those are kind of different, but what links them is that essentially there are too few providers at competitive prices, so prices are bid up.

So, you end up in some sense, if you knew what that competitive rate is, saying that rates were too high in that market.

Second possibility is what a relative equilibrium or the possibility where true monopsony can occur, that is the market -- the input market now -- is roughly in balance, and you would end up with basically competitive rates.

An important one -- historically, in particular, a very important one -- is an excess supply market. And this is a case where, at competitive prices, what would normally be competitive prices, you have too

many providers and, therefore, rates are bid down.

Now, I split the box subtly there, or others have done it for me. Suppose we had a monopsony merger -- that is, a merger that was suspected to generate monopsony -- what would be the effects in each of these markets? Well, as I think Ted has -- and even Mary has touched on this -- if it's an excess demand market, the prediction is that -- or bilateral monopoly situation; that is, where there's a monopoly seller or monopoly provider -- we would expect that the countervailing power notion, while Jeff is completely right, it's an indeterminate bargaining range, the expectation is that that sort of bargain would lead to a decrease in rates.

The amount of providers in the market would probably be unchanged, if there were excess demand, or possibly would increase the amount of output or providers -- we could measure it either way. That would, basically, as others have said, be a good thing.

In the relative equilibrium or instance where true monopsony can come up, this is the situation that causes the misallocation of resources, we would get a decrease in rates, which, as Marius has already described, seems to be a good thing, but you would get a decrease in the amount of inputs higher and the losses to the sellers, as he put it, are greater than the benefits

of the decreased rates. So, that's the potential monopsony situation.

What I want to do now is contrast that with what you might observe in the marketplace. And suppose, then, that we started from excess supply -- and don't even consider that a merger is occurring -- we're just wondering now, is there monopsony power out there? What you would see in an excess supply market -- and, again, historically very important -- a lot of the law suits are based on history -- historically very important -- you would see that if there are too many doctors, too many hospitals, too many beds -- whatever the measure of the excess supply is -- you would see reimbursement rates falling and you would see some reduction in the amount of capacity -- doctors moving, doctors not coming into the market, hospitals closing and merging, et cetera.

Now, the important thing to notice is, that looks like monopsony. That looks like the relative equilibrium situation that describes a potential monopsony problem.

So, what does monopsony look like? Well, a couple of reminders: The first one we just discussed. You have to make sure you can distinguish the excess supply market from the true monopsony. There's also an issue that Ted and I talked a little bit about yesterday,

you have to distinguish the possible success of managed care and the reason it arose, of course, was to try to constrain unnecessary care and moral hazard issues in the insurance markets, and that is a reduction. And, so, you have to be a little careful that what you're measuring when you see reduced output in the market that you don't just simply label that monopsony; when, in fact, it's supposed to be a success.

And very important, I don't want to jump over this, this is kind of to remind everybody along the way, the whole thing that matters here is the elasticity of supply. What that means is that if wage rates or payment rates or reimbursement rates change, what does that do to the amount, the capacity that can be purchased at that rate? We may come back to that more.

And another warning, another cautionary note: The effects have to be marketwide. This is really just like on the monopoly side, saying we protect competition, we don't protect competitors. Same thing in monopsony. You're talking about the whole input market. It's not sufficient for one hospital or one group of physicians to come in and say that they've been abused.

What do we look for? Well, let me give you sort of the practical edition. Again, I want to emphases, this is a pattern of multiple factors; this is

not a checklist, this is not a -- this is what you might see in the real world if monopsony were present. I want to emphasize that it can't be just a few factors. You're really putting together a pattern of evidence. And there may be things that I've not included.

Many of these are fairly hard to measure, actually. A decline in market output -- I mean, that's the single biggest prediction of monopsony. So, if you have some sense of when the alleged monopsony started, and you're looking for -- you've got to control for population growth, et cetera -- but does market output actually decline -- the input market output?

Is there a pattern of provider exit? And that's got to be due to low rates. It can't be due to a malpractice crisis; it can't be due to other sorts of issues like declining population. You'd have to somehow tie it to the rates.

I guess the obvious part, do you see, in fact, a large and dominant provider? That is, is there a large share of total reimbursements -- marketwide total reimbursements -- from the alleged monopsonist? And, again, this was discussed yesterday in the market definition. I would argue that it includes all payment sources, not just commercial.

Monopsony has the prediction that the

monopsonist behaves the way it does because it perceives that every time it raises payments, the real price of payments is going up very quickly. That occurs only when there's a single rate; essentially, for specialty here. So, you would expect, if you're looking at monopsony, to see pretty much single rates. You wouldn't see a lot of contract negotiations and you wouldn't see -- not because one is just imposing -- it's just that there's going to be a set rate in monopsony.

Marius raised this as well. There is price discrimination through negotiations. That is not a bad thing when it comes to monopsony. What is does is it says that you are -- to be technical about it -- moving up a supply curve instead of moving up this other curve that economists talk about called a marginal factor cost curve that really is the reflection of the monopsonist perceiving that its wages are increasing at a higher rather than they really are.

In other words, if you don't have a single rate -- if you do have price discrimination -- then you don't have the incentive that causes monopsony.

You would also perceive low reimbursement levels to providers. Obviously, the complaint. Low compared to what? That's certainly an issue and, I guess, I'll go the next one, which is you have to find

appropriate benchmarks in order to do that. So, you'd want to look at payment rates and similarly situation but competitive buyer-side input markets. But, also, you would perceive little variation, because everybody is going to have this rate imposed on him or her, if they're a doctor, and the facility, if it's a hospital.

You would also perceive limited opportunities to treat noncommercial patients. This is both Government patients and -- well, various forms of Government patients; basically, Medicare and Medicaid, CHAMPUS, and others -- because that gets us to the switching issue as to whether you could actually turn to other buyer sources.

You would also perceive low incomes for physicians and low profit margin for efficient providers. Now, what I mean by efficient providers, I mean to exclude -- there's always some hospital, some physician group that's just not very well managed, and you'll get low rates for that reason, but you would generally perceive that incomes have been beaten down and that margins have been beaten down.

Again, you would expect little variation, at least with respect to these efficient providers. The idea is that these efficient providers have done everything they can to overcome this monopsony power and

they find themselves all in a similar state. You need, of course, appropriate benchmarks there, too.

Some other thoughts: And I think this is a critical one, because it gets to this notion of are you dealing with an excess supply market or not? Is there systemic excess capacity by providers marketwide? If there is, then you can't really say that the decrease in price you're observing has to do with monopsony, it probably just as easily has to do with the market coming into equilibrium, as I suggested earlier.

You'll find few rival insurers. This is -- obviously, Stephanie's data show that it's pretty rare that there are few rival insurers, but you would find that the providers have contracted with as many of those insurers as possible and done the switching that they could do to overcome the monopsony.

Low rates by those alternative provides. That just makes sense -- doctors, hospitals, in order to encourage those other providers, would be offering them low rates if you had the monopsonized group and the nonmonopsonized group, those should equilibrate in a given market, so you would probably expect to see those low rates.

And this has already been mentioned as well -- entry into the insurance market. That is the output

market condition is very important. Because, obviously, if there are cheap prices in a market, in a sense the providers can be hired for cheap prices, then one would expect other insurers to be attracted to that market, especially if the monopsonist is keeping it as profits.

Let me take -- these are hypothetical cases, there's nothing dispositive about this, this is just to give you a sense of what a monopsony -- just in a quick look -- does this look like monopsony?

Two types of cases I'm going to present: One, alleged unilateral monopsonization and the case typically -- and there's more than one of these cases, actually -- but a hospital is suing an insurer claiming that the insurer has monopsony power.

In the commercial insurance segment -- I call it a segment not a market because it's not the only reimbursement source available -- let's say we have a defendant insurer with 70 percent of the commercial market. And let's say we have a plaintiff hospital in the alleged geographic market that is suffering, shall we say, a -3 percent margin. Presumable, that might look like it's monopsony. But, again, we're talking about competition in the input market, not a single competitor.

If you look at all of the hospitals in all of the counties, you get quite a variation -- some making

money, some not -- even within a county, there are both types of hospitals. These are acute care hospitals. So, just on its surface, this doesn't look like monopsony.

The weighted average for the five counties is a 2.6 margin, that's not terribly out of line with what national averages are, so, you know, that also doesn't look like a problem.

You'd also want to consider, as I said before, occupancy rates and the notion of excess capacity. Is this an excess supply market? Well, the plaintiff hospital has 73.5 percent occupancy rate for the year. You may have your own rules of thumb; my rules of thumb are, from listening to CFOs of hospitals, that you can -- most acute care hospitals are good and happy -- not that many are there -- but in the low 80s -- 85 for a year is usually humming along pretty well. And, after that, you have some tense days if the units are full.

But, let's look at the variation in occupancy rate. Not only is there variation, but there are plenty of people well below a reasonable capacity, a tight capacity, and even below the five-county weighted average. So, to me, just on the surface, this doesn't look like monopsony.

Hypothetical case two: This is alleged conspiracy to monopsony. These are sort of the provider-

tracked type cases that we're hearing about. There are state-level cases, there are certainly the multi-district litigation kind of cases. So, in this case, the hypothetical is a physician provider group, whether they are class action or not, suing a group of insurers claiming that the insurers underpay and hospitals have closed as a result and physicians have left.

Now, let's look in this hypothetical MSA that's affected by this case. There is a three-county total of hospital beds in '92 of 5,800. It has fallen for a simple annual average of 4.5 percent decline in each year. Well, that looks like hospitals have exited the market. That might be a problem.

If we compare that to the state total that's also fallen, the U.S. total has also fallen -- maybe it's not so much of a problem -- the hospital industry, in general, is contracting, as opposed to a local area where the monopsony effect might be felt. But, you know, it's hard to read a lot into this amount of data and, so, I suppose -4.5 percent is a bigger number.

But, let's see what's happened to occupancy during this period. Despite the shedding of all that capacity, occupancy is really -- this is really close to a national average -- occupancy has not gotten to what I would call efficient levels and what I'm sure all the

hospitals in that market would wish were efficient levels -- so, it's really hard to say that just because there's been a reduction in beds, this wasn't anything other than a necessary reduction in beds.

With respect to physicians in the same area, the physician counts, '98 to 2000, we don't see a reduction in physicians; we see a growth in physicians, and when we compare it to the state and the U.S., it looks pretty much in line.

Now, really, this should be adjusted for population growth. I mean, I haven't -- I mean, I don't have that -- I didn't have that data right at hand, but my guess is that this particular area is not a rapidly growing area compared to either the state or the U.S. total, so I suspect these would be represented.

Anyway, all I wanted to do with that is to suggest to you that even with a quick look, you can get some sense as to whether you think -- far more analysis than is needed, I have to emphasize that -- there are many, many factors -- but, you can get a sense as to whether there is likely to be monopsony power in some of these areas where there's claim to be.

Thank you.

(Applause.)

MR. DICK: Thank you very much, Tom. We're

going to take a break to, say, 10 past 11:00, and reconvene with the next set of speakers of the panel.

Thank you.

(Whereupon, there was a recess from the proceedings from 10:58 a.m. until 11:12 a.m.)

MR. DICK: All right, we still have a number of speakers to hear from and our roundtable, so I'd like to reconvene. And to lead off the second set of panelists, I'll introduce Dennis Hall. Dennis is the President of Baptist Health Systems. He has been in that capacity since 1994 and has been associated with Baptist Health Systems for more than 20 years. He's a Fellow of the American College of Health Executives and a Trustee of the Alabama Hospital Association Board.

MR. HALL: It's good to be here. I'm just going to take a few minutes allotted to me. I told somebody outside in the hallway, I feel like I've been in an airplane at about 30,000 or 50,000 feet flying over the Amazon and people arguing about whether there are crocodiles and piranhas down there.

(Group laughter.)

MR. HALL: I'm going to take you down there where it is and tell you exactly what's going on in my state and in my hospital and some other folks here at the FTC and the Department of Justice have to figure out

whether there are some market issues or not. I'm going to talk to you about the real world and what the real results are.

Let me just say a couple words about Alabama. I guess we're a relatively small state with 4.4 million people living in our state; 13 percent of them are over age 65 in the age category; 16 percent of the people in our state live in poverty. Alabamians clearly have a very poor health status, which ranks 48th in age-adjusted death rates for all causes across the board. The reality is is that this results in high utilization for physician visits and high hospitalization admissions in our state.

I want to talk a little bit about Blue Cross in our state, the most dominant and significant force in health care insurance in our state. They are also the Federal intermediary for the Medicare program in the State of Alabama.

Just in terms of looking at market share, you can see out of a population of 4.4 million people, it's estimated that Alabama Blue Cross/Blue Shield insures almost 1.2 million people, with over 26 percent of the market share, and just so you get an idea, if you look down at who the other providers are -- the HMO and the other insurance companies, by Blue Cross/Blue Shield's own admission, they insure and control about 80 percent

of all the non-Governmental work in the State of Alabama.

It was interesting for me to hear a previous speaker say that, well, when you look at market share, you ought to consider all payers. Well, all those other payers provide us rates by Government edict. And, in the State of Alabama, that means hospitals break even, at best, on those rates.

So, the only opportunity we have to generate any kind of margin for a hospital in the State of Alabama is commercial insurance. It's the only place we have to go.

A recent article indicated that when you focus on just a small business market, Blue Cross/Blue Shield controls almost 90 percent of it -- 87.4 percent of all the small business insurance in the State of Alabama, just underscoring the dominance of this carrier in our state.

Now, what does that mean to hospitals? According to the Alabama Hospital Association's recent survey, almost half of our hospitals are losing money on their Blue Cross contracts -- 18 percent of them, losses in excess of 9 percent. And, then, you say, well, what about the other hospitals? Another 23 percent of the hospitals reporting that they're only breaking even, with margins a little better that 3 percent.

I was kind of interested in that average number that was quoted up here that averages across the country are about 2.4 percent. It's nice to think about averages, but you get those averages by including a lot of huge losses. Thirty -- nearly one-third of all the hospitals in America are operating in the red -- one-third of all hospitals are operating in the red -- and in Alabama that number approaches 80 percent of the hospitals in our state operating in the red.

If you focus on, well, what about over on the physician's side? My system operates about 50 clinics with about 150 employee physicians, we find the same kind of impact when we start looking at the rates paid for physician visits.

The Medicare rates are clearly not competitive rates, but even when we compare the payments of Medicare rates across the board, with few exceptions, we find that what the Blue Cross plan is paying us is substantially below what Medicare pays physicians.

We at Baptist Health Systems, we're the largest health care provider in the State of Alabama. We operate 10 hospitals in central Alabama, with about 1,700 physicians on our staff; 9,500 employees; clinics; home health; every kind of diversified health service that you can think of, we're involved in.

As we look at our cost per case, we're the lowest cost-per-case provider in the Birmingham area. We're also one of the lowest cost-per-case providers in the southeastern United States, according to a recent VHA benchmarking study.

We buy supplies at some of the lowest costs in the nation; we've got our revenue cycle management in the top 10 percent of the nation. Now, you would think a provider that's managing its resources that effectively ought to expect to have a margin on their commercial insurance business.

The reality is, we suffer substantial losses in taking care of Blue Cross patients in the State of Alabama. The lowest cost provider is suffering substantial losses taking care of Blue Cross patients in Alabama.

I told you that we don't fare well in Alabama with our Medicare rates. So, when you stack that up against Medicare and you begin to look at the losses that this system is experiencing -- breaking even on Medicare and then having your major commercial provider provide us rates that are clearly well below our costs -- you can begin to see the impact that they have on the overall financial status of this system. The results are, today this system has no access to capital.

Blue Cross, the percentage of our work reflects pretty much what the situation is in the State of Alabama. What's interesting is when you look at the amount of net revenue we receive from them as a percent of our business, you begin to see immediately that Blue Cross is having a tremendous detrimental impact on the overall financial system of the largest health system in the State of Alabama.

Now, you might say, well, if that's the situation, Dennis, and they only have 26 percent of your business, just cancel your contract. It would seem to me some of the speakers up here were suggesting that. Just cancel your contract. Well, when I look across at the major physician groups in the State of Alabama, 30/35 percent of their business is Blue Cross.

If we took the position and cancelled out contracts, where do you think those physicians are going to go practice? They've got to survive; they've got to take care of their patients; and they're simply going to move their business to other area hospitals.

So, indirectly, this plan does not control just 26 percent of our business, it controls 50/60/70 percent of our business. We're in no position to have any kind of level table negotiations with the group Blue Cross plan in the State of Alabama.

So, today, just looking at where we are today, this is a system that's barely breaking even. Almost a $700 million revenue stream with the lowest cost in the region; with some of the lowest costs in the southeastern United States, barely breaking even; with capital needs that approach $70 million a year and no access to capital because of the financial conditions of this system.

One of the strategies that we used several years ago was to try to form our own plan, a PHO. We had it licensed as an HMO. We grew it to 120,000 employees. We found ourselves subjected to predatory pricing. We found in rate negotiations that people were telling us that in the future we may not want to contract with you, we may want to get into selective contracting because we don't want to contract with a competitor. We eventually exited that business. We exited that business.

Today, the Baptist Health System, and its Board of Trustees, are discussing strategy solutions to maintaining the continuity care in our communities. We're looking at mergers; we're considering the possibility of having to sell our system; we're talking to people who might be potential capital partners; meaning they will take control of the economics of the system. If we do none of that, we've got to stop serving our communities and eliminating services that we have

traditionally provided. We've already done much of that. We've got to forego some of the state of the art technology that you and I would expect as patients if we were in the hospital; and postpone capital improvements, sometimes things as simple as a leaking roof.

Now, I don't know about all this discussion that's gone on prior to me, but I know what it's like in a canoe on the Amazon River when everywhere I look there are crocodiles and alligators.

Thank you.

(Applause.)

MR. DICK: Thank you. Our next speaker is Steve Mansfield. Steve is the President and Chief Executive Officer of St. Vincent Health Systems and prior to joining St. Vincent, he was the Chief Executive Officer at Baptist Memorial Hospital-East. He is also a Fellow of the American College of Health Care Executives.

MR. MANSFIELD: Thank you, Andrew. My intent is to try to serve as a second case study. I think, hopefully, to generate some discussion among our panelists later about the implications of our market and health care law and other aspects that we may have a chance to discuss.

As Andrew said, my name is Steve Mansfield, I do have the honor and privilege of serving as President

and CEO of the St. Vincent Health System and have been there for about three years, and I appreciate the opportunity to have a chance to come and speak to the group and to share my experiences and my concerns.

And, before I go further, I'd like to take just a second to contextualize what I'm going to say by sharing a little bit of information with you about St. Vincent, to give you a little bit of a feel for our health system as it exists today.

St. Vincent is comprised of five hospitals; our largest is the St. Vincent Infirmary Medical Center; we have the Doctors' Hospital -- I'll show you some pictures in just a second and talk a little bit more about that; north of the river, we have St. Vincent Medical Center-North; and adjacent to it a 60-bed rehab hospital; and then we have one real hospital in Marlton, which is about an hour northwest of Little Rock; we have 13 primary care clinics; two joint venture surgery centers; four specialty clinics; a B&A that serves most of central Arkansas; a Breath Center joint venture; we have 700 physicians that comprise our medical; and we have 350,000 in/out and clinic patient encounters on an annual basis.

If you look at the State of Arkansas, we are very much located in the central part of the state, and, again, most of our presence is Pulaski County, which is

Little Rock and North Little Rock.

Now, let me go through quickly and just share with you some of the aspects of the system. Our first location, in 1888, we were founded by the Sisters of Charity of Nazareth, from Nazareth, Kentucky, and this was the first location. We remained there for a little bit over a decade when we moved here, and, as some of our folks from Little Rock may remember that building. I've only been there three years, so I don't. And from there we moved, in 1954, to its current location, which at that time, in 1954, was the far western perimeter of the city.

In 1994, we added the St. Anthony Hospital in Marlton. It's a very well-run regional rural hospital, and we have a long-term operating lease with that facility.

In 1998, we merged -- the Columbia Hospital in the city and with St. Vincent, bought them out of the market, essentially. It serves primarily as a specialty hospital today.

And then opened our newest hospital, north of the river, in -- actually, in Sherwood, in 1999. And there's our medical center today.

St. Vincent has a legacy because, in part, of its tenure in the state, of many firsts. We were the first hospital established in central Arkansas, in 1888,

as I said earlier; we were the first to open a hospital-based nursing school; the first to open a nuclear medicine school; we're the first in the state to develop and open an intensive care unit nursery; we introduced the first PET in the State of Arkansas in 1995; and we're the first in the state to perform minimally invasive cardiovascular surgery and have performed many of the new cardiovascular procedures at St. Vincent; we were the first in the state to perform, in 2002, endoscopic vein harvesting for CABG procedures; and we were the first hospital in the state to introduce a medical cyclotron, which will open next month.

The essence of the health system is really in this slide. We have a tremendous commitment to our mission; to serve both the poor and the medically indigent. We provide $5.6 million annual of charity care; $22 more of uncompensated care; the Medicare and Medicaid patients. We have four free clinics, which are a great case study, because they're staffed by emeritus physicians and by retired employees of St. Vincent -- nurses, pharmacists, social workers and so forth. We do subsidize those $360,000 a year just for supplies and medications and so forth. And we have a 20-year partnership with the City of Little Rock for an outreach clinic, which is in a poorer part of the city. In total,

our charity programs -- our charitable mission -- touched 112,000 Arkansans last year and rang up a total of $29 million of unreimbursed expenses.

Today, I feel that that mission is threatened by some aspects of our market, and, frankly, that is in large part the reason that I am here.

In 1997, St. Vincent joined Catholic Health Initiatives, which is the second largest not-for-profit health system in the country. You can see in the shaded area of the states where Catholic Health Initiatives has hospitals, and you can see we're the only health system they have in Arkansas.

Now, let me address for a moment the product. From the standpoint of quality, service and cost, many of the ways that Dennis measures and benchmarks his system is certainly true for us, as well. In our most recent accreditation survey from Joint Commission, we received a score of 96, which is better than average, during that cycle of accreditation visits.

We do have several five star health grade programs; we have been in and out of the solution top 100 hospitals for orthopedics; we participated with Catholic Health Initiatives in an award that they received from the National Care Quality Award; from a patient satisfaction perspective, the Jackson Organization

Surveys our market every other year, and their survey in December of 2002, on key indicator questions asked of 100 discharged patients from five area hospitals, two of them being ours, we scored higher south of the river in Little Rock on seven out of eight of those indicators and on eight out of eight north of the river.

And our costs, as Dennis mentioned earlier, I think in part because our reimbursement from our managed care plans is lower than Blue Cross reimburses, we are excluded from Blue Cross and, because of that cost structure and a low net patient revenue -- we have the lowest net patient revenue in Catholic Health Initiatives -- we've have to take our cost structure down.

And, so, we've aggressively taken our costs down. Our costs today -- despite double-digit increases in input costs -- are at $4,973 on a case mix index, adjusted discharge basis, which may not mean anything to a lot of you, but it does put us in the top 25th percentile in the solution data base that we participate in.

And a key thing, too, I think about that, is that we believe that we are substantially below our primary competitor in the Little Rock market on a cost basis, and we'd like to have an opportunity to pass that along to consumers in a way that we're not able to do

today.

This quotation from the Center for Studying Health System Change, I think, is a good description of our market as it exists today. It says, "The diagnosis for Little Rock's health care market isn't good. With Arkansas Blue Cross and Baptist Health System being the dominant insurance and hospital system in Little Rock, it's difficult for other competitors to get a toehold." The only thing I might add to that is to maintain a toehold.

There are many aspects of the Arkansas market that affect all hospitals in the state, not just those who are excluded from Blue Cross, and it's fair, I think, that we should mention those. For one thing, we are 50th in Medicare reimbursement, per admission, in the entire country. We received $5,175 per Medicare admission, the highest reimbursement in the country is $11,439, and the average is $6,951. I say this a little tongue in cheek, because I think I recognize someone that I worked with in the past in Mississippi when I was there for seven years, but we are 50th, Mississippi is 51st, and in Arkansas we have a saying, Thank God for Mississippi.

(Group laughter.)

MR. MANSFIELD: But we had that same saying in Mississippi, except it was, Thank God for Arkansas.

(Group laughter.)

MR. MANSFIELD: We are dramatically underfunded, as is generally the case, with our Medicaid program in the state, and a little bit unique, I think, we have a huge portion of our population that are uninsured today -- between 400,000 and 500,000, depending upon whom you read. Now, that's 16 to 18.7 percent of our state population. And, also, probably corollary to that, we only -- only 45 percent of employers provide health insurance in our state, which is the second lowest in the nation.

Very few health plans remaining. We've had out-migration according to the State Insurance Commissioner's Office of 78 health plans over the last 10 years, either have left the state, scaled down their operations in the state or gone bankrupt. Sixty-six of those have occurred in the last five years, which seems to me indicates an accelerating pace.

The Arkansas Blue Cross/Baptist partnership, which I'd like to talk about more specifically in just a moment, but I want to underscore something here because I have people in the room that I consider friends, who are with Baptist and are with Arkansas Blue Cross/Blue Shield. I want to say that, in all sincerity, I believe both are very good companies. Baptist is a very good

hospital company; they make as better by competing with them; and Blue Cross does many good things for the individuals who have insurance through Blue Cross. It is that partnership and the effect of that partnership on our market that is the question for me.

Of late, one specialty niche hospital, we have a MedCath Heart Hospital there -- it probably did more damage to St. Vincent when it opened in 1996-97, maybe, than even to Baptist, because the physicians who bought into the MedCath operation were historically St. Vincent physicians. They were on the St. Vincent campus and when they moved their practice to Heart Hospital, it did have a profound effect.

And, as others have said, you know, the way that PPS was set up, when it was set up in 1983 and continues on until today, there's some services that you make money on in the hospital business and there are others that you do not, no matter what your cost structure is. And, as a rule of thumb, you make money, typically, or have a contribution margin, on about 80 percent of procedurally and surgically related DRGs and you lose money on about 80 percent of medically related DRGs.

So, acute care hospitals, like our hospital, or Baptist in Little Rock, is very dependent upon being able

to cross subsidize the losses we have for patients who have medical DRGs by treating those who are surgically or procedurally oriented. It's just the economics of the way respective payment works, primarily.

And, so, it's not rocket science to figure out if you want to be an investor in the hospital-type business and you just want to do it in one area, it's not hard to figure out where you start, and that's why we've got a lot of things going on in cardiovascular. We're starting to get more in orthopedic spine and working their way down. You know, I ask my medical staff quite often, why don't you guys open a COPD hospital? You know, and I think there's a real good answer to that found in the way it's reimbursed by Medicare.

We do have, as Dennis mentioned earlier about Alabama, a comparatively poor health of our population. I don't how it compares to Alabama's, but I know that that is an issue for insurers, health plans and hospitals in our state.

And this slide is really true, I think, for hospitals around the country, because I know right now there's a real effort underway to try to determine why are we having double-digit increases in the cost of health insurance and so forth, again, and everybody's kind of pointing the finger at one another.

I would just say to you that as it relates to the hospital systems, and that's what I only talk about that because that's all I know, you know, hospital margins, as has been mentioned earlier in the 2.5 to 3 percent range and declining, our premiums that most of us get -- not premiums but our net patient revenue we get from insurance companies and even Medicare on a slight basis -- has improved, but if margin is going down, it has to mean, to me, that expenses are rising faster than that. And that is the dilemma that we face in our particular location and I know Catholic Health Initiatives faces as a health system.

And there are a lot of reasons for that: unfunded Federal mandates, while they are a great idea; HIPPA is a great idea; some aspects of IMPALA are a great idea, but when they come unfunded and you do not have the ability to pass that onto anyone, that is an additional cost that has to be absorbed out of rates within margins already.

Also, double-digit increases in nursing and other wages, we've had to just -- Mark doesn't know this, but he can take it back and share it with the folks at Baptist -- but we've had to adjust our registered nurse salaries up by 17 percent this week in order to stay competitive with others in our market. It is a function

-- not something they or we wanted to do -- it's a function, really, of having almost 1,000 vacancies in the hospitals across the state for registered nurses today.

We've also had double-digit input cost increases for pharmaceuticals, malpractice liability insurance, pension costs and health insurance for our own employees.

In addition to that, as Dennis mentioned earlier, it's very expensive to stay up with technology, but it's very crucial, also, because many of the physicians that you want practicing in your hospital come -- they have very expensive toys. And they're going to go where they are. And, so, trying to stay current with that is definitely an ongoing expense that challenges the bottom line, again.

The introduction of drug-relating stance, which is a great idea for the consumer, is something we all need to do, but it's going to come as an unfunded, for at least a period of time, an unfunded additional cost to the health care system. For us, it's $1.3 next year, and that's expanded across hospitals across our country.

And we have biventricular ICDs. We have an ability now to treat congestive heart failure in a way we've never had before. The problem is, it costs $30,000 per -- and -- it's not reimbursed. So, that challenges,

again, an already challenged aspect of our economy.

Now, let me move to talk just a little bit about, from my vantage point -- and that's all I can represent is my vantage point -- and it's kind of like, you know, depending on what side of the road you're on for the parade, you may see the parade differently, okay? I understand that; I know I do not see it the way Sharon does and others do, but it's my turn now to talk about how I see it, so ....

(Group laughter.)

MR. MANSFIELD: This is what concerns us. When a seller and a purchaser, each with significant market power, which Baptist in central Arkansas and Little Rock in particular, and Blue Cross have, team up in a way that has a significant exclusionary effect on competitors, the ultimate impact is felt -- or potentially is -- in decreasing quality across the health system and increasing prices paid by consumers.

Now, that's easy to say and it's a lot harder to demonstrate, but let me take you through some of the thoughts that we have as it relates to that. And I want to go back and take just a moment, if I may, to describe, if I could -- and Sharon is obviously better with this because she was involved with it -- I know it more anecdotally -- but, in 1992, as was happening across the

country, there was an effort to try to get control of rapidly escalating health care costs, and managed care kind of came on the heels of a failed Clinton initiative and was the answer. And, frankly, it did. It took health care costs down. I would contend it took it down at the expense of hospital reserves and many times at the expense of physician incomes, but, be that as it may, it did occur, and a lot of the philosophy at that time, which did hold true, was whereas we had been in a business that was largely charge-based -- we charged something, we got paid for it. It's kind of like the way the grocery store works.

But what happened with managed care is managed care companies were able to come in and say, we can bring you business, Baptist or St. Vincent, that you have historically not had, but we will only do that if you will discount your pricing to us. That's a logical argument. In other words, you've got a smaller margin on each increment, but you've got more increments.

And, so, as Blue Cross weighed that decision in Arkansas, they did make the determination that in all cities, which there are only nine of in Arkansas -- if we are a real small state, I'm not sure what we are, but we're smaller -- we have 2.6 million people in the state. But, in those nine communities, Blue Cross selected one

hospital provider to the exclusion of others, and that, basically, has continued unabated for a decade now.

The impact that it's had I can share with you in just a second, as it relates both to the effect on what was already the largest market player on the insurance side and what was already the largest market player on the hospital side. And we'll talk about that a little bit further.

They also, Baptist and Blue Cross, had merged what used to be competitive HMO products into an equity company that allows them to compete in a way that's a little atypical with regard to establishing prices for that HMO product. I think that is an issue in our market, as well.

I could go on, but I'm going to stop there, and maybe we'll talk about it more in the question and answer, but the impact, I think, of this 10 years now, of this tightening relationship and this mutual growth that's occurred in both Blue Cross' market share and Baptist's market share is that, as I mentioned earlier, we've had 78 health plans leave, scale back or go bankrupt in Arkansas since 1992. The plans that are remaining are struggling in a mighty way.

QualChoice, which is the only plan, to my knowledge, that is certified to provide insurance in all

75 counties in Arkansas, other than Blue Cross, is struggling mightily under the watchful eye of the Insurance Commissioner's Office, because their reserve level is below what's statutorily mandated for them. They are very, very fragile.

United, which is the second -- distant second -- largest health plan in our state, with about 13 percent of the commercial market, in order to compete more effectively, has consolidated their processing in one location in another state. They have very few employees remaining and, frankly, in my view, do not have an intense interest in the Arkansas market to the degree that I have seen them have in other markets where I have worked.

Aetna and CIGNA, which you typically would think of as large players as well, are largely there only servicing multi-state accounts. They do not compete effectively, in my view, with Blue Cross for most of the array of plans that Blue Cross offers.

There's been a dramatic impact on physician dynamics. Time is not going to allow me to talk about all of those, but a key factor is that specialists, in order to take care of Blue Cross patients, my understanding, specialists have to be on the staff of an in-network hospital.

The impact for us is that that meant that St. Vincent specialists, in 1992, had to join the medical staff at Baptist for the first time and have had to continue that. That has a trickle down effect, again, that I'd love to visit about, but probably don't have time to do now.

There has been in our state -- it's true across the country -- double-digit increases for many employers over the last three or four years for health insurance premiums, but I can assure you that we have not gotten anywhere close to averaging double-digit increases in what we receive from our array of health plans that we work with.

And there's been a profound impact on the excluded providers. I mentioned the 10 cities, you've got three of those that are currently for sale; widening market share gaps for the others; and the typical financial pressure that you would expect. I've got a list of the excluded hospitals, and I'm not going to spend any time on that.

And this slide is probably, I would suspect, more controversial than some of the others, because there is a debate about what the exact market share within the commercial market is for Blue Cross. I think the reason there is a debate is it's very difficult to determine,

because it's not in any one given place. You don't go one place and find it.

And Blue Cross' numbers, I don't know if they count TPA accounts -- I think they should because those TPA accounts also are affected by the same network that excludes St. Vincent and other providers around out state.

If you pull out -- we took the NAIC report, pulled out all life insurance and property casualty companies and ended up with a slide that looks like this. We have gotten estimates from everybody that's taken a look at our market since I've been there that their market share is between 65 and 75 percent. This methodology would hit in the middle of that, that's 2001, I don't think it's gone down. Another way of looking at that.

The impact for Baptist and St. Vincent, you can see we had about a 12 percent difference in admissions in 1992, between our two systems, that's grown to 70 percent 10 years later. I think Baptist has testified here that 25 percent of their admissions, which would be about 10,000 admissions, come from Arkansas Blue Cross/Blue Shield.

And, the unfortunate slide that I hate to show, but it's the reality of what we're living and struggling

with, is this is our financial performance over the last five years. And we, basically, are maintaining our ministry currently through not spending to the level of our depreciation, so that helps; we have monetized a lot of our non-hospital-type functions, like clinics and some of those things we've sold to other people in order to raise cash. We have seen a diminishing number of day's cash, as you would expect. It is a situation that is not sustainable into perpetuity. And, hence, the great concern that I have for our mission.

And let me say in closing that the Little Rock market is, in my opinion, very unhealthy, with few beyond Baptist and Blue Cross, who seem to prosper. In our 115 year history, St. Vincent's mission has never been more threatened than it is today. Frankly, if that were because our costs were too high or our quality was too low or we lacked access or our patient satisfaction were poor, than I would just consider that we were getting what we deserve from our marketplace.

But, in fact, our costs are lower, our access is equal, our quality is as good or better and our customer satisfaction is better. Yet, the market share erodes and consumers pay more than I believe they should in health insurance premiums because we're not able to pass along our lower cost structure to them.

And my question that, I guess, I came here with and look forward to hearing answered in a few minutes, is: Why?

Thank you.

(Applause.)

MR. DICK: Thank you. Our next speaker is also going to provide a marketplace perspective, that's Sharon Allen. Sharon is the President and Chief Operating Officer for Arkansas Blue Cross and Blue Shield. She has been affiliated with Arkansas Blue Cross for more than 30 years. She's also a member of the Board of the Little Rock Chapter of the American Heart Association and the Juvenile Diabetes Research Foundation.

MS. ALLEN: Good morning. I am Sharon Allen, President and Chief Operating Officer of Arkansas Blue Cross and Blue Shield. Today I'm here as the representative of a company that's some 55 years old. It's a not-for-profit mutual company. All of our policyholders, and all net income goes into reserves for those policyholder, not to investors or to stockholders.

We pay state premium and Federal income tax to the tune of almost $64 million for the timeframe of 2000-2002. We employ 2,200 people, with seven full-service offices spread through the state. We established those seven regional offices because we happen to believe that

health care is a local issue, it's local in nature, with different issues and needs, depending on the location.

So, we have established local presence to work with the providers of care and the citizens of the various communities throughout the state. No other insurer has done that in the State of Arkansas.

Our service area is limited to the State of Arkansas, unlike the majority of our for-profit competitors. Therefore, we are, as someone said earlier today, reliant upon scale economies derived from membership volumes specific to our state boundaries.

We are, indeed, the largest health insurer in the State of Arkansas, with a comprehensive portfolio of products.

What are our competition drivers? Our focus is on meeting customer needs and expectations. We do that by trying to deliver consistent quality services and deploying technologies and products specific to the need of our market.

We do have relatively large provider networks, PPO and HMO, and we believe they're sized to meet the health service needs of our customer base.

You've heard this before, and some of my numbers are not necessarily going to match Mr. Mansfield's -- maybe we can compare notes after this

session. Arkansas is a small, rural, economically poor state, with a 2.6 million population. Five hundred and ninety thousand (590,000) of those citizens live in the Little Rock/MSA four-county area.

We are a very unhealthy state, like Alabama, with extremely high disease burden. We exceed averages in terms of heart disease, cancer, stroke and unintentional injuries. Our poor health status ranks 46th in the nation.

There is an uninsured rate of 16 percent statewide; it's about 428,000 people; and 11 percent in the population within the MSA that I'm specifically talking about today.

Medicaid population is roughly 19 percent statewide and 16 percent in the Little Rock/MSA. We have a high percentage, roughly 16 percent, of over aged 65 and disabled population, compared to the total population, and there's 13 percent in the Little Rock/MSA.

If memory serves me correctly, we are either second or third in the elderly population -- second or third only to Arizona and Florida.

In terms of the acute care delivery system -- and let me hasten to add that when I give you the hospital counts and the bed counts, I have included all

hospital beds with the exception of psychiatric and rehab; in other words, there have been some specialty hospitals -- children's, the Heart Hospital, because we think they render community and acute care.

Statewide, there are 82 acute care hospitals, accounting for 11,337 beds. Forty percent of those beds are in single hospital communities. In the Little Rock/MSA, there are 13 hospitals with 2,828 beds. And on a statewide basis there are a total of 4,763 physicians, of which 3,394 of those are specialists.

The MSA accounts for 1,807 physicians, with 1,397 of those being specialists. And I would tell you that 28 percent of the physician population practices in single hospital communities and 40 percent of the physicians in the Little Rock area, the MSA cross-over and practice at multiple hospitals.

Our PPO and HMO networks are extensive, in order to provide the access for our customers on a statewide basis.

The statewide totals I just mentioned, our PPO and HMO networks include 83 percent of the hospitals; 73 percent of the licensed hospital beds; additionally, 77 percent of the primary care physicians participate in our PPO and 74 percent in our HMO; while 67 percent of specialists are in the PPO; 65 percent are in the HMO;

and in the MSA, participation rates are similar, but with 78 percent of primary care physicians participating in the PPO and 76 percent in the HMO.

According to my counts, and I'm probably counting this a little differently than Steve is, but there are only eight sites in the state, utilizing the Little Rock/North Little Rock area as one, that have multiple facilities, as you can see on this map.

In the Little Rock/MSA, as I said, there are 13 hospitals, 2,800 beds, and all of those hospitals are clustered within a 35-mile radius.

Now, with that sketch of our company, a glance of the characteristics of the state and the MSA's population, and the delivery system composition, I'd to address the issues surrounding Arkansas Blue Cross/Blue Shield, Baptist Health, Advantage, our market share, the competition and contract policies, which I prefer to call business models.

It will not paint a true picture to limit the discussion of these three items to only the Little Rock/MSA, because the Little Rock area is the place where individuals with very serious illnesses or those needing complex procedures and special needs are generally referred.

The Commission, in addition to understanding

this point, also needs to understand that the facilities within the Little Rock/MSA have changed significantly, as well. Many community hospitals in the MSA, and actually throughout the state, have certainly become more tertiary in nature and, thus, referral patterns have changed in the last several years.

To give you one example, within the Little Rock/MSA there are 13 hospitals. Five of those 13 hospitals have established full-fledged heart programs. So, people are no longer being referred in to Little Rock, necessarily. And, fairly recently, as you've heard before, a specialty heart hospital was also opened.

We have 740,870 members within the state and 147,558 within the MSA. I will hastily tell you that includes under-age 65 population; we have excluded from that count our Medipac, which is the Medicare supplement; and we've also excluded out-of-state membership where we have a company that resides in Arkansas but has locations elsewhere and we are known as the insurer of those out-of-state locations, as well, because they do not affect the market in Arkansas.

Compared to the total population of the state, we have a 27.5 percent statewide market share; 25 percent within the MSA. You'll notice that we have a large number of self-funded. If we removed the self-funded,

where the large employers are making their own decisions, then you can see the market share drops considerably.

Right down by product types, we tell you that on a statewide basis, 19 percent of our business is HMOs; 71 percent of it is PPO and indemnity accounts for 10 percent. And you can see what the situation is within the Little Rock area, also.

What's the nature and the mix of competition? Mr. Mansfield would have you believe there is no competition in Arkansas. I beg to disagree. There are the traditional multi-line carriers who compete in virtually every product line and rely heavily upon scale economies and standardized product offerings as a competitive edge.

You, then, have got the specialty or what I call niche companies, who are competitors who differentiate themselves to be a sum combination of lower price, greater product flexibility or highly individualized customer service or, sometimes, unique provider affiliations and sponsorships.

There's the big three national players: Aetna, CIGNA and United; there are two large local health players, that being us and QualChoice; there are 64 in-state and out-of-state TPAs operating in Arkansas and we,

like most other states, estimate that roughly 45 to 50 percent of the total covered population is in a self-insured situation.

There are seven statewide provider rental networks and two unbranded, out-of-state Blue Cross competitors in the form of Unicare and Health Link.

There were, in 2002, 168 licensed insurance companies marketing health policies in Arkansas with over $100 million in annual premiums; that would be on a multi-state basis. That came straight from the Insurance Department.

The largest private employer in the state happens to be self-administered. They self-administer their own claims and they use a rental network. The second largest private employer in the state maintains their own provider network via direct contracts and uses a TPA service of a national health carrier.

And, then, we've seen the recent entry of new directed health care competitors in the form of Definity Health and Illuminist.

Let me talk for just a minute about our business model. We have exclusive contracts. Do we contract with everybody in town? No, we don't. Actually, let's attack the HMO piece to begin with.

It is an equity split ownership between us and

Baptist System and 240 Little Rock area physicians. We own 50 percent; Baptist Health System owns 25 percent and the physicians own 25 percent. It's an IPA-type network model that has no ownership of physician practices.

This might be a good place for me to tell you, also, that in 1999 a state law that was enacted that required insurers, HMOs, with limited networks, to offer options such as point of service, open access, PPO or even indemnity products that would allow employees to have a choice of out-of-network providers.

Today, what we are seeing the market demand and what we are selling the most of are open access and point of service, which indicates the patient may go to an out-of-network provider, such as St. Vincent's. There would be some additional expense with that.

What do we think the major strengths are of this type of arrangement? First of all, we think the equity arrangement that we have developed allows us better to focus on high quality coordination of health care deliveries and administrative cost efficiencies. It gives us an achievement of continuity and predictability for equity partners relative to long-term capital investments in new products and technologies.

We believe it provides better patient service levels and continuity of care than in traditional arms-

length, independent contracting-type relationships where, many times, a patient is caught in the middle.

And we have a PPO, that's another part of our portfolio of products that is marketed under the name of First Source. It is wholly owned and operated by Blue Cross and its subsidiaries. It, basically, is a negotiated, discounted fee-for-service, based on patient steerage via classical class volume considerations.

The strengths, we believe, is that it's a relatively large physician network, constituted mainly of physicians with staff privileges, plus other credentialing criteria, at in-network hospitals.

The method we have chosen or the business model we've chosen generates a cross-town competition by typically contracting with only one major acute general hospital in communities with two or more hospitals.

I might mention, as David pointed out for hospitals that were up for sale that were not in our network, he didn't tell you they are all Tenet Hospitals. Plus, there is one that is in the network, located in Russellville, Arkansas, that is a single hospital and we do participate with it, and it's up for sale, also. All of the Tenet Hospitals and, I guess, several other places, are up for sale.

Then we have our indemnity, our standard any-

willing-provider or product. That's a standard AWP structure with basic features of agreed-upon fee reimbursement levels and patient hold harmless for over-the-range charges. It's available, as an option, to customers who do not want patient steerage, features of a typical PPO or HMO, and virtually every licensed hospital and physician in the state participate in that model.

I want to emphasize very strongly that there are no Arkansas Blue Cross or health advantage provider contracts that contain any of the following provisions:

We do not have a favored-nations clause. We do not, contrary to some comments that I believe were made earlier in one of these sessions, have exclusivity in terms of contracting with competitors. We will offer an exclusive contract, but we certainly do not expect the providers to return that.

Physician hospital gag provisions do not exist. And, for whatever it's worth, comparable packages of PPO health benefits in the Little Rock market, with these models, average 13 percent below the national average for like health care coverage.

Are we a monopoly or a monopsony? I think not. We are a customer-focused, market-driven entity that has worked hard to provide affordable health insurance to the state's citizens. We believe the Little Rock health care

market will continue to be driven by a combination of national competitors -- the Uniteds, the CIGNAs, the Aetnas -- by local statewide players, such as QualChoice and us; and a large number of both in and out-of-state TPA-oriented niche specialty entities.

For those of us who compete in virtually all product lines, that's both the national competitors and our local statewide players, economies of scale, based on enrolled membership volume, will continue to be the key to determine whether or not our ability to remain competitive over time stands.

Sizable local enrollment, in particular, is critical to Arkansas Blue Cross/Blue Shield Health Advantage, given the fact that national-level competitors can leverage economies of scale on membership basis that are 15 to 20 times our size because of our confinement to the state boundaries.

I appreciate having the opportunity and look forward to the discussion later on.

(Applause.)

MR. DICK: Thank you very much. I'll introduce now our last, and by definition the most patient panelist, Stephen Foreman. He's the Director of the Pennsylvania Medical Society Health Services Research Institute where he carries out and directs research on

health insurance markets. Previous to that position, he was on the faculty of Health Policy at Pennsylvania State University and also has held research positions at the University of California/Berkeley.

MR. FOREMAN: Thank you. It's Friday and it's competitive effects. I'm going to limit my remarks to about three areas, although, as Tom said, after you've gone with all this, you're tempted to throw it all out and start fresh.

But I'm going to make some observations, generally, about competitive effects, market power and some of the places where that leads. I'm going to deal with some technical considerations in terms of the questions posed to the panel and then I'm going to end with where are the implications of all of this.

Yes, reasonable people can differ and people can come at this from different sides, and one of the things I really want to emphasize is we need to take a look at this from a system's standpoint and making it all work together. That's imperative for all of us that we do that.

And what do I mean by that? Well, you might have thought I meant medical care, and I sort of implied that. But we actually believe, on behalf of our physician members, that protecting the competitive

process, which is a cliche, is actually true in terms of what's going on here.

We believe that all actors in the health care system, both on the physician and hospital side, where we provide services, health insurers who buy those services and resell them to employers and then employers and consumers as their patients, we believe that economic health throughout the system is absolutely imperative.

We believe that competition, fair, open competition, enhances access, quality and price at every level of these markets. We believe that's good for everybody.

Unfortunately, we see that the competitive process is imperiled. You heard some of the stories this morning about it; you can look at this issue in city after city across the country, and, at a minimum, you can ask some very deep, probing questions about what in the heck is going on here?

And that's a starting point. You know, no matter how well meaning a pricemaker is, you know, why do we care about a pricemaker? Well, even the best meaning of pricemakers, which can be a nonprofit health insurance firm like the one we just heard from, can make mistakes. And that's really part of the buried-in issue here. I'll touch on that briefly.

Also, sort of as an introductory remark, although a lot of this has been cast in terms of merger and merger discussion and merger standards, we think this is not just a merger problem. Mergers look to future conduct and future activities. We would urge the FTC and Justice Department to undertake a major survey of all major health care markets in the United States and to look at those markets in terms of structure and conduct.

What I'm saying is, you're hearing a lot of opinions here, and you don't have to believe any of us -- go look -- and see what you find.

Second, there have been a lot of mergers that have been approved over the last 10 years, we actually think that a lot of promises are made in the context of those mergers and we would like to see you go back and take a hard look at what was promised and what resulted in terms of those mergers. We think you might be surprised.

I'm going to agree with Tom in a couple of areas here. Unlike some of what I heard here, we think there are substantial problems with competition in a lot of markets in this country. A lot of what was posed as competition are red herrings. We think that there are red flags that you can look at in terms of spotting a potential market problem in an area and here are some of

the ideas that I had, some are Tom's.

The first one would be concentrated market shares. Begging the market share question that we discussed a long time yesterday, once you answer that, if you see highly concentrated markets, with firms with large shares that persist over time, and there's no entry, that should at least raise a going and red flag.

Parenthetically, there is a relationship between monopoly share and monopsony, and I'll touch upon it a little bit later. You can have monopsony power without monopoly. But, on the other hand, if you have, in this industry, if you have a monopoly share in the health insurance market -- say you had a 50 percent share in a state -- somewhere in that state you will have a 50 percent share in the market for buying physician or hospital services, by mathematical definition, almost. There's a couple of exceptions, but by and large that holds.

Another thing you might want to look at is persistently large high levels of profit without new entry. Extremely high levels of surplus reserves on the part of health insurers is something you ought to pay particular attention to, particularly after our discussion yesterday about entry barriers and, also, in terms of what's going on in the downstream market. How

are health insurers using very high levels of reserves? What implications do they have? Yes, we want them to be financially stable, but we also want the other players in the market to be financially stable, as well.

Another thing you might look is what are the proportion of employer contracts that are quoted on a take-it-or-leave-it basis as opposed to negotiated? And the corollary to that -- and we talked about it some yesterday -- what's the proportion of physician contracts in an area that are put out on a take-it-or-leave-it basis? And if that proportion is substantially -- and we've had some disagreement about that -- if that proportion is substantially high, that's telling you that there's something going on here that physicians aren't willing to walk away from a contract.

Some other things that are really important -- and I'm going to use a Pennsylvania example -- we've lost 1,000 physicians in the last year and a half, out of 28,000. And, Tom, says, well, some of that's malpractice, premiums, and I say that's exactly the point. When physicians are priced down close to their margin and when their practice costs go up and there's no way for them to pass along those costs in the cost structure, their option is to leave the market.

So, malpractice costs actually make the point

rather than undermine it, and the issue of hospital exits is of the same nature.

In fact, just as a transition, I want to give us some room for pause here. I mean, just to put all this in perspective. You know, I listened to Dennis and it moved me. This is the other side of the ledger. These are the 10 largest, for-profit, health insurance firms in the country. The people with which physicians would gladly give their -- any power they are presumed to have had. We've heard about physicians' market power; well, here's the flip side.

And if you look at this, many millions of Americans receive their health care insurance from 10 firms. I did this table a couple of years ago, it was seven million back then. And that's grown to 10 million, and those firms made $4.8 billion -- this is from their year-end SEC filings and this is before tax. Parenthetically, the 10 biggest Blue Cross firms added another $1.4 billion.

So, if you put that in contrast to some of the financial figures that we saw on the part of the hospitals earlier, the question here is why isn't there substantial new entry -- this is what's called low-hanging fruit -- why aren't firms coming into these areas four wheel and engaging in full and open competition to

take these profits away?

And, by the way, this is the fourth year of these kinds of profits, and there hasn't been substantial new entry in a lot of the areas where these firms operate.

Another issue, I think, that we need to consider and lay to rest is that monopsony is sacking the public interest. Jeff sorted of alluded to it a little bit earlier. Isn't it a great thing that we have health insurers that can go in and hold down costs? But what they're really doing is holding down prices. In the end analysis -- and we really accept the traditional monopsony view of all of this -- that what this results in is depressed quantity of production and suppressed quality in the long run. In the long run, monopsony power harms everybody.

There was some discussion yesterday about physicians and physician pay levels. Mark is fond of saying that, if you wanted 1954 level health care costs, you could just have the kind of health care that we had in 1954. And if you think that through, that's pretty profound. And think about what you're going to get.

Parenthetically, yesterday we heard about how physicians in Europe make so much less money than here and sort of the tag-on to that is, if you would like

European-style medicine, we can reduce price; but the fact of the matter is, people in Europe want to come here for their care because this is the best health care in the world.

You know, what I'm saying is that buried in this is both a quality and a quantity effect and monopsony can cause problems both ways.

We heard some talk earlier this morning and yesterday about the economies of scale that large health insurers produce. Ruth Given yesterday called it bargaining economies of scale. A little while ago, Sharon called it the economies of scale from membership.

We don't think these are real economies of scale. Real economies of scale come from improved technology in the ways that you do things better. While bargaining power is monopsony power, it's not an efficiency or an economy.

In effect, we believe that there is price-making behavior in the input market for medical care. We believe that the benefits of payment reduction, that many physicians see and many hospitals see, aren't being passed along to employers downstream, and, in sum, we think that the idea of bargaining economies of scale is misplaced.

In terms of some of the questions poached for

the panel, I'm going to just deal with four or five of them, very quickly. The issue of switching costs, the question of where you move from bargaining power to monopsony power, abilities to influence the market, downstream ramifications, and some conditions for the exercise of monopsony power.

The first point, I'd like to agree with Professor Schwartz on, and that is one of the principal things you want to look at here are what are the costs to physicians of their ability to withdraw from a provider network? That's a key concern here, because a lot of these things -- and I'll put it in the context of physicians -- you get hit with a take-it-or-leave-it offer that pays you 80 percent of Medicare and, now, your decision is, what are you going to do?

Well, if you withdraw, there are costs attached to that. First of all, there are very high transaction costs. Just finding replacement payers and entering into agreements with them can be expensive; there are administrative costs in switch-overs with billing agreements; for some physicians, particularly specialists, there are entirely new sets of referral patterns; and, I guess, if you're expecting physicians to move, which I don't think there's an answer here, there's at least the cost of the move and dislocations.

In addition to what I mentioned yesterday, there are opportunity costs here which haven't been studied and, I think, this situation pertains to the UCC equivalent of a lost-volume seller.

What do I mean by that? Well, if you could replace -- suppose you're a physician with 5,000 patients and, you know, Aetna represents 2,000 of your patients, they give you a take-it-or-leave-it offer you can't live with, you want to drop their 2,000 patients, so you go out and you find 2,000 other patients that you can take on -- which is a big if and a problem.

The fact of the matter is, you could have kept the Aetna patients, if you were paid decently, and gone out and gotten those 2,000 other patients and actually expanded your revenue base. So, it's really a lost-volume seller situation.

And, finally, something that hasn't been discussed in great detail, the replacement from these so-called competitors may look a whole lot different from the firm that's given the take-it-or-leave-it offer that you may want to leave, contracting with some PPA or some PPO in Arkansas can be a whole lot different than contracting with Blue Cross/Blue Shield of Arkansas, at least I would hope so.

What did I mean by considering system view?

Well, the monopsonist reduces overall quantity in order to reduce price. We heard some discussion from Tom earlier and yesterday that you ought to factor Medicare and Medicaid patients in this mix. Well, if you've moved to a monopsony setting, Medicare and Medicaid patient demand stays constant. By definition, in the classic setting, you're going to have less quantity demanded when you have a monopsonist-reducing price.

So, on the overall, what I'm saying is that some physicians in the system will lose patients. It may not be the physician you're looking at. He may be able to replace, but after all this all shuffles around and you've reduced quantity demanded, quantity supplied will be reduced in the long run.

So, what I'm saying is that switching, in some ways and at some points and levels, becomes -- not only very high in terms of costs -- it may be illusory.

Market sharing costs. Professor Schwartz said that not only are the costs of withdrawing high, they can be nonlinear. The more patients that you have to replace, the higher your switching costs that are attributable to them, we agree with that. We think that switching costs probably rise as a multiple of share and it might not just be linear, it might be geometric.

Next question: Where do you cross the line

into monopsony? Clearly, we believe, there's a level where increased share merely increases your bargaining power, that it's not monopsony power. Sure, a little bit more, but not a big deal.

Clearly, there's some area where you have all of the market, you're the only buyer in town and you've crossed the line into a monopsony setting.

What we're suggesting is that, given those parameters, somewhere in there, you've crossed the line. If you go to the buying power index that we've discussed, share matters -- although share, necessarily, alone, should not be used, because elasticity in supply matters, but there are some bright-line tests, I think, that you can fashion to give some direction to people and to put some people on alert and to tell you when you might want to take a look at something that might have happened.

There are guidelines that suggest 35 percent -- this is from a footnote in Roger Blair's book; Areeda and Turner suggest that should be 25 percent; we actually think it might even be lower than that, depending on the market and some of the other supply elasticities and the Frech elasticity of demand.

Price reduction: Unlike Tom, we define monopsony power, as posted in the guidelines, as the ability to impose a small, significant, nontransitory

reduction in price without substantial switching. And that's the definition that I would use.

By the way, that definition goes to the ability to switch, not actual switching. So that in a merger case, you're looking at the future, not something that's already happened, and you're put to the test of asking whether someone could do that as opposed to whether they have done it in the past.

We believe that it ought to be enough, in a monopsony setting, to show the potential ability to reduce price, and, particularly, because it's very hard to prove what competitive levels might be in the future or might have been in the past.

What about the potential to reduce output? We suggest directly that monopsony power implies that the monopsonist has the ability to reduce output in order to reduce price. Once again, it doesn't have to have already occurred or be occurring -- the question is whether someone has the power to do it, particularly if you're looking at a merger.

The danger here, as I pointed out before, is that the economic factor, not the market, is making welfare-reducing determinations. And, in effect, just to sort of overlay a couple of comments on that, you know the very fact that these contracts are negotiated doesn't

mean they're competitive or that the market is competitive. In fact, that begs whether there's a strategic conduct behavior going on, because in a truly competitive market, there wouldn't be negotiation. You'd have many small sellers and many small buyers and everybody would be price-takers.

Must a health insurer be a monopolist in order to be a monopsonist? The short answer to that is, no. Part of the reason is tied up in the fact that market definitions differ from one side of the ledge to the other. You could have a 10 percent share in a region -- I'll use Philadelphia as a quick example -- you could have a 10 percent market share in the health insurance business in Philadelphia and in one county in that area you could have 100 percent share. I mean, it's possible.

However, note that the inverse isn't necessarily true in health care. And what that means is that monopsony in the health insurance market implies -- and it's the reason why we start in short form looking at that because it's easier to measure -- monopoly power in the health insurance market implies that there will be some market power in a monopsony market within the same area, mathematically.

What are the conditions for the exercise of monopsony power? Well, monopsony power, as I said

before, is the ability to impose that small nontransitory price reduction. We think that, in answer to your question, that the buying power index that comes out of Roger Blair's book is a good way to look for conditions and that you should very carefully consider substantial market share switching, which we've already discussed, and something that I don't have time to get into in any great detail, and that is the low fringe buyer elasticity of demand.

We've heard an awful lot about competition this morning, people have thrown out numbers in major markets about the numbers of competitors, but in a lot of those markets, you know, let's take Boston with seven or eight or nine firms, you may have one or two firms with market dominance and you may have seven or eight that really constitute fringe buyers. And if those fringe buyers don't have credibility with employers and aren't able to expand their operations due to license capital requirements, you really don't have any fringe buyer elasticity of demand.

So, that's a consideration that really ought to come to play here. I mean, just because somebody says that there are 89 firms in the market doesn't mean, you know, that most of those firms can actually take up and step in and substitute when there are monopoly profits.

So, how do we conclude? Let me put it down. A number of health insurers have the power to impose a small, significant, nontransitory reduction in physician fees. What am I saying? We think there are markets where there are monopsonists. In particular, physicians are vulnerable to take-it-or-leave-it fee schedules, and if you don't think they have been, come home with me and I will take you to go visit some people -- lots of people. This vulnerability translates into problems for those physicians, but more so it translates into problems for patients and for all of us.

I work for the Pennsylvania Medical Society, my wife has acid reflux disease, and she was told she had to wait five months for a gastro-intestinal -- GI appointment, and could I pull strings?

So, I appreciate your time this morning and we'll be on to the question and answer.

(Applause.)

MR. DICK: Okay. I'm going to propose that we take a very short break, maybe just five minutes, let people stretch their legs, and reconvene in five minutes and we'll start our roundtable discussion.

(Whereupon, there was a short recess from 12:28 p.m. until 12:39 p.m.)

MR. DICK: All right, I'm going to try, with

the panelists' indulgence, to more or less adhere to our initial promise that we would round up not much past 1:00. I know people have been very patient in listening and I don't want to tax people's lunch time needs.

I notice and it was kind of curious that both the opening remarks and the closing remarks by the panelists sort of identified two issues that ran, really, throughout many of the presentations, and I wanted to toss up sort of a couple of questions and give each of the panelists an opportunity to elaborate on these two points.

And those were, it seems like if there's agreement on nothing else in this diverse group of analysts, everybody, I think, seems to agree that there are at least two conditions necessary for us to conclude that there's an exercise of monopsony power in a given market. And both of those conditions, it seems, would need to be present -- not just one of them.

The first one that a number of people emphasized was some kind of switching costs, that it's not just costless or immediate for say a physician or a hospital that loses some portion of its revenue stream to somehow make that up from other sources. If there's not a switching cost present or significant switching cost present, it seems pretty hard to imagine how one would

have a concern about monopsony.

And the second criteria and the second factor that a number of people emphasized, obviously, is market share, and people talked about different market shares -- whether it's the share locality-wide or marketwide or whether it's the share for a given hospital or given physician practice that a given insurer represents, or maybe some combination of those two. And, again, you know, even if you had very high switching costs for replacing lost business, but we're talking about a very low market share relevantly measured, again, it seems hard to imagine how there could be an exercise of monopsony power that we would be concerned about.

So, again, it seems to be sort of the interplay between those two economic variables. And, so, I wanted to give each of the panelists, if they want, an opportunity to talk a little bit more about how, in practice, an agency like the FTC or the Department of Justice should be able to figure out, if they were looking at a particular merger or were looking at a particular business practice in a market, figure out whether we're sort of at or beyond that sort of threshold market share or whether we have observed switching costs that have risen to a level of concern. You know, what kinds of tools should we be thinking of, should we be

trying to develop, if we're going to answer those practical questions.

So, I'm going to go through the panelists in turn and give everybody an opportunity and I'll also give them the luxury, if they want to sort of answer a different question and maybe take advantage of the fact that I tried to keep people to 15 minutes and if they wanted to elaborate or respond to something the other's said, I'll give them that liberty. But, I'd like each person to take maybe just two or three minutes and try to answer that question.

So, I'll start this on the far end of the panel, just to keep in simple.

MR. MANSFIELD: I don't have a response to that, really. I mean, our issue is, we're an excluded provider, and we don't have switching costs because we don't have anything to switch out of. Do you know what I mean? But I do think we had some issues.

MR. HALL: Well, just as a hospital provider, I would just have to say, you just sort of think about on a practical basis, if you've got a plan that has 25 percent of your business, the thin margins or no margins in the hospital business today, no hospital can stand to lose that kind of revenue. So, their ability to negotiate is gone. They can't stand that.

And then you raise the question, well, is there an opportunity in that marketplace for them to switch to another plan? Well, if you've got a plan that has 70 or 80 percent of the marketplace, the ability to switch to another plan is just completely inconceivable. Because, first of all, the only place you're going to get those patients and doctors are from other providers, and the other insurers have such a slim piece of the market share that even if you were relatively successfully in doing that, you, basically, have given up 20 or 25 percent of your whole revenue stream and most hospitals just can't survive at that.

I'd just like to say one other thing, because somebody raised this question earlier, and said, well, you know, excess capacity ought to be viewed as any time you drop below 85 percent or something of occupancy rates in hospitals. Well, I have to tell you in today's state, that is absolutely ludicrous and it's ludicrous for this reason: Hospitals today are moving more and more to outpatient status. We fill beds constantly with outpatients -- one-day stays, 24-hour stays -- and, so, I would suggest to you if you have a hospital running 70/75 percent today, you have a relatively full hospital that is really stretching its capacity to keep patients in beds, because such a huge percent of those patients today

are outpatients, they are never registered on the inpatient side of the enterprise.

So, you have to be very careful about these kind of benchmarks that were used years ago today to measure whether there's excess capacity in a community.

MS. KANWIT: I thought, Andy, there was more disagreement than agreement on issues such as market share and switching costs. Just on the market definition, I heard Steve Foreman talk about markets as low as 25 to 35 percent; and then we had Tom McCarthy and my paper, which talks about market shares in monopsony equivalent to monopoly-type market shares.

But, basically, I made the point in my presentation that a market is a market depending on how you define the market. I mean, you've got physician markets, you've got insurer markets, you've got geographical markets, and what I didn't like is that everyone is coming out from a deductive standpoint, starting with the definition, and then trying to get to the answer that they really wanted at the end there on markets. So, I don't really think that that's particularly helpful.

I also don't think it's very helpful in this particular industry -- I hate to call health care an industry, but I guess it is -- in this industry because

the barriers to entry are so low. So, the market share is variable from, literally, one day to the next.

On the switching point, if we're talking about consumer switching, I mean, we in the health care arena, the health plans that are members of AHP, would love it if consumers and employers wouldn't switch in and out as much as they do. I mean, they're busy switching to the tune of maybe 25/30 percent a year from health plans, and it costs money to switch. There are administrative costs that are involved with that kind of switching. But there's enormous -- that's a lot of switching going on out there.

As for physician switching, I think some of the other people can talk about that better than I.

MR. MILES: Is the question what you all should look at to do sort of a quick see to see if an investigation should be opened?

MR. DICK: Yes.

MR. MILES: Okay. I guess, before you're going to need to worry about switching costs, there need to be alternatives to switch to, and I think that's where I would start. I would try to look at the market. I do think market share is important, but I also think concentration is important, and I also think the characteristics of the different competitors in the

market are important. In other words, are they significant factors? Is it likely they might become significant factors in the market? Or, are they simply fringe firms that are going to stay fringe firms that really now and in the future are going to exert very little constraining effect.

And the only way I know to do this is -- and I know this sounds simple because you all already do it -- and that is make some telephone calls to market participants and get their perceptions on those issues.

MS. ALLEN: Andrew, I would only add one thing. I think Jeff has pretty well summed up what my thoughts would be, also.

I guess another question that I would ask, we talk about fringe players and are they only going to be fringe players? There might ought to be a question asked of why? Why are they only fringe players? For example, in the State of Arkansas, we have seen companies leave the state and I told you some of the reasons why. It's a small state; it's a small market; it's economically depressed; we have a horrible, unhealthy health status. You know, it's not the Mecca of the world.

But, I mean, I think some thought needs to be given to that when you start talking about market share and, you know, if there's someplace else for them to

switch.

MR. FOREMAN: I was going to tease Lawrence about going to Arkansas and opening up a health plan, too.

We don't think that entry is all that easy. We don't think expansion is all that easy. Switching costs actually makes sense and I think I defer to Professor Schwartz on a lot of the concepts there.

If you're looking for a number, always you're tempted to say, well, it depends on facts and circumstances. But I will tell you that for most physician practices that I know, they can ill-afford to lose 20 percent of their revenue. Now, to go to a point in time when they're faced with high legal liability costs that are jumping through the stratosphere, for some physicians in my state, if you took away 10 percent of their revenue, they'd leave.

So, with the temptation to say facts and circumstances, I mean, there are some pretty low numbers that really alarm physicians.

MR. MCCARTHY: That's the way markets adjust, inputs leave, and the question is, where do they go and what do they make when they get there and how do those markets equilibrate.

But let me go specifically to switching costs.

I think that there are ways for physicians -- I think it's less true of hospitals. I think hospitals have a much bigger challenge here. But here are ways for physicians to switch. They close their practice. In other words you don't give up people to replace, you just say I'm not taking on new ones.

And, then, what you do, because there are -- and this evidence was presented in the Aetna matter -- there are many employers in big cities who offer multiple plans. And physicians can -- it's happened to me -- physicians can encourage their patients to consider other plans. So, that's one point.

But the real point I want to make is, one of the assumptions in a monopsony model -- and we covered this a little yesterday -- is that the quality of the product is unaffected by whether it's a monopsonized inpatient market. But if you start paying your doctors, particularly in the case of Aetna, where Marius your model quite rightly points out that this is more of an impact for somebody who has a high Aetna-plus-Prudential share, if you think about it as a business strategy, it doesn't make much sense. If you're going to beat up your doctors and yet they are the ones in whose hands you are placing your most valuable commodity, the members, then the quality of care falls and those patients don't want

to stay with your health plan.

So, unlike monopsony of, you know, sugar or monopsony of coal or textiles or something, the product that actually is consumed by the consumer is of lower quality. It was exactly the DOJ's concern. If the quality is lower, you don't have to worry so much about switching, the patient will switch themselves.

Now, having said that, there are at least three comments about one of the first things to look at and I think it is also why the fringe stays a fringe, why the alternatives can't expand, because there's really no reason why they can't expand their capacity very, very quickly. There must be something else going on. I don't know the full answer to that, but that's what I would explore.

MR. SCHWARTZ: Well, of course, I'm not going to give you the answer to the question you asked, but let me say a few things of relevance, and starting with a reply to Tom McCarthy.

The point that monopsony wouldn't make sense as business strategy, I take issue with that, because, sure, you might reduce the quality to your patients, but if you, the HMO, are making more money at the doctor's expense, you can afford to compensate the patients for the lost quality. You see, you take a little bit of

anti-quality or maybe a big bit, will cut the price accordingly. So, there's a way to offer them at the end today a price-quality package that induces your patients to stick with you and, yet, still makes the HMO better off by having ripped off the doctor -- bad word, but anyway.

MS. KANWIT: What if the HMO is doctor-owned?

MR. SCHWARTZ: The second point is, I think the switching points are not trivial -- and this is just based on talking to or what I heard from the interviews that we did with physicians at that investigation.

For example, a significant fraction of employers, I'm told, offer only one plan. So, if you're a patient and you want to stick with your doctor, you know, you'd like to do that by switching to another plan, but if your employer doesn't offer another plan in which that doctor participates, you've got a problem. That's just one example.

Now, let me go back to Andrew's question and take slight issue with his claim that at least two conditions are necessary -- two conditions need to hold -- both of them as opposed to either one -- in order for monopsony -- and the conditions were, one, switching costs, on the part of physicians, let's say; and, secondly, a significant market share on behalf of the

payer.

Well, I'm not sure you need switching costs. You can have the standard textbook monopsony without switching costs. That is, if you had 1,000 doctors in the market and they could all easily switch their patients and get patients from any one of the many payers, that's a no-switching-cost case.

As long as one of the payers ends up with say 60 percent of the patients in that locality, you would still have some monopsony power. What switching costs adds is the potential to magnify the market powers that would arise if you were predicting solely based on the payer's locality-wide market share.

So, it doesn't mean that in the absence of switching costs there's no potential problem. What switching costs do is they say you may have a problem even if locality-wide market shares are ordinarily what you think would be too low for a problem.

Now, what switching costs then do is essentially they -- it's conception with the economic theory level -- they mean that the market for physician services is not necessarily a locality-wide market. It becomes, you know, a series of little submarkets.

And, so, you know, our physician group that's contracting with particular payers, you know, that's the

relevant universe that we need to look at.

Now, this is relevant to one of Tom's points, where he said that we only have monopsony behavior if the price falls marketwide. Well, that's not true. In a case where you can -- your contract is separate with different physician groups, if you can impose a price reduction on one group and impose it by, let's say, accepting a reduction in output in the services that you buy from them, and -- and this is important -- if you do not make up that loss output from other physicians, then you've got a problem. You've lost some output here, you didn't make it up over there, end of the story. It means you don't have a problem marketwide, but you do have it in the narrower market.

Now, Tom did raise a very important point, which is that -- and that's a point that other people have touched on -- which is we tend to use monopsony to mean too many things. And that's absolutely fair. And one of the nice things he pointed out is he described, with your third case, I believe, was called excess supply. What are the initial conditions on excess supply?

If you then, let's say, have a merger that increases the buyer's power, the result of that may be lower prices and exit by providers and, yet, that would

not be bad, was the inference I drew.

Well, that's an interesting case and the interesting thing about that is it looks awfully similar to monopsony -- lower price and lower output, perhaps.

And the wrinkle here is that what's happening in that paradigm is that what the HMO has done is it said instead of contracting with all 100 doctors, I'm going to contract only with 50 -- pay them a lower price but guarantee them a higher volume.

At the end of the day, the total volume that's purchased by the HMO may well go up or certainly not go down. All that's happened is that it has reallocated that from some physicians to others.

Now, that reallocation is something that we've heard complaints about over here. And I don't want to dismiss those, I'll come back to that in my minus 10 seconds I have left. But, that reallocation is not necessarily innocuous, but it is a different animal from monopsony. Monopsony is marketwide output reduction.

The example I gave was one where you reduce the price and the quantity from certain doctors, you leave others unaffected, you still have a monopsony problem.

In Tom's example, where you're reallocating, absolutely that could be an efficient practice. You're offering the members a reduced choice of providers in

exchange for a lower price. Fine. At the same time, there is a negative impact that's been ignored; which is, if the HMO is lowering the price -- back up a sec -- what we think of as excess capacity, meaning a lot of providers, all of them below some capacity level, there is a benefit from that; namely, variety. It's good to have more providers around. It reduces transportation costs, it appeals to various preferences, and so on.

So, if you reduce the prices to a subset of the doctors -- I'm sorry, if you stop dealing with a subset of the doctors and shift your volume only to others, yes, you get a lower price; yes, your members may be better off; but if those doctors, in turn, are driven to exit, as in your example, that loss in variety is something that harms the entire rest of the universe. So, I don't think that one should be quite as hanging on that point. I don't think it's necessarily an antitrust concern, but based on economics, it's not a no-brainer.

MR. DICK: Well, I had a whole series of brilliant questions --

(Group laughter.)

MR. DICK: -- but our time is up and my commitment of getting you to lunch and completing this on the scheduled time frame exceeds my desire to ask those questions. So, I'd like to thank, on behalf of the

Federal Trade Commission and Department of Justice, I'd like to thank everyone for coming. We're going to reconvene our next set of hearings on April 7th -- I'm sorry, May -- I always do that -- May the 7th, and we're going to do a day and a half May the 7th and May the 8th, and I hope you can be with us then.

And I'd like a last round of applause for all of our panelists who have shared their insights.

(Group applause.)

(Whereupon, the workshop concluded.)

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

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CASE TITLE: HEALTH CARE AND COMPETITION LAW WORKSHOP

HEARING DATE: APRIL 25, 2003

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

DATED: MAY 13, 2003

SONIA GONZALEZ

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.

DIANE QUADE