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I N D E X

P R O C E E D I N G S

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MS. OVERTON: -- from MCRA, Microeconomic Research Consulting Associates; we have Meg Guerin-Calvert from Competition Policy Associates; John Marren from Hogan, Marren, Limited; Jeff Miles from Ober, Kaler; and Ernie Weis from Advocate Health Partners. We're going to go ahead and get started with a presentation from Jeff Miles.

MR. MILES: Thank you. It's always interesting to be over here and talk to you. It's interesting, to look around the audience, I see so many people who probably know more about this subject than I do. I should invite some of them up here to talk. I want to do two things. I'm afraid I'll eat this thing if I get too close to

it.

I want to do two things this morning. I want to give you really just an overview based on my experience with regard to PHOs and the antitrust issues that I've run into. And then I want to talk, if I have time, about one case in particular. We have some people here who are familiar with that case. It's a case called U.S. v. Women's Hospital Foundation, case brought against a PHO and a hospital back in 1996.

PHOs are sort of a phenomenon of the '80s, the late '80s and the '90s. Like so many other provider networks, they were set up for mixed reasons, I would say. Like other networks, initially a lot of them were set up to take risk when risk was a lot more prevalent and popular than it is now. A number were set up as alternatives to managed care organizations that were moving into the area at the time, and I think we have to admit some of them were set up to try to deter entry by managed care of block entry.

In my experience, I think the primary reason I've seen them set up is to -- as a physician, quote, bonding technique between the hospital and its physicians, I hate that word bonding, but that seems to the favored expression of the hospitals. To try to induce more loyalty by physicians to the hospital. And in some cases, and I'll get to that in a few minutes, it's been alleged that this loyalty rationale was set up -- they were set up as an entry barrier to new hospitals coming in or expanding in the market.

And I'll talk about that. A lot of PHOs were not successful. They've

gone out of business. There's been some talk that PHOs are dinosaurs today. At least in my experience, that's not the case. I still work with a number of PHOs, some of which have been very successful. And a lot of that work today involves trying to make sure that the PHOs are operated in a way that does not raise antitrust problems because, as I'll mention in a minute, there are a number of PHOs that with regard to physician fees have been using fee schedules for a number of years. And, of course, that can raise a problem, and certainly one that especially today interests both of the agencies.

The antitrust concerns that PHOs have, I think, are one reason that PHOs and other types of networks really are waning in interest today. The message seems to be slowly getting out to physicians and hospitals that it's difficult to use networks as a method of increasing bargaining power without running afoul of the antitrust laws. And certainly over the last year and a half to two years it looks like both agencies have become much more interested in network price fixing issues.

When you look at the antitrust issues PHOs raise, many of them are exactly the same issues that an IPA raises or a provider-controlled PPO raise, and I assume there's really no sense in going back over those issues. I think they've been discussed pretty fully during the hearings. But, of course, the PHO adds the vertical aspect to it in the sense that the hospital and its physicians, in a sense, are a different level in the chain of distribution because the hospitals are, or the physicians are referral sources to the hospital. Although if you look at the concerns that the PHOs have

raised so far, at least in my experience and also in looking at the cases that have been brought, the vertical issues really have not been much of a concern, at least so far.

Statement nine of the FTC/DOJ Health Care statements addresses multi-provider networks, and PHOs are a type of multi-provider network. As I mentioned, the primary focus I've seen on the antitrust ramifications of PHOs have involved the physician component price fixing issue that you see in other types of provider-controlled networks. The antitrust issues and the analysis is, I think, identical for the most part to that in analyzing any type of provider contracting network. The ancillary issue goes to the question of how the physician fees are set: whether there is a price-fixing arrangement; if there is a price-fixing arrangement, whether it's a naked arrangement or an ancillary arrangement.

And one of the things I spend a good amount of time today working on is converting PHOs from networks using a fee schedule of some type to a network using some form of messenger model. And if you've never done this, I can tell you it is a real trip and very challenging. A lot of people think that they can read the enforcement statements and understand completely what a messenger model is and how to implement it.

And my experience is so many little procedural questions that you never expect to arise on the front end do arise and it can be quite a challenging endeavor. Questions regarding how coverage is going to be handled; if some of the providers in the network aren't included; referral problems that can arise, if other

specialists in the area that are members of the network are not included in a particular network. Just a number of little logistical problems that are often overlooked.

I've seen several PHOs that have considered and some are even attempting to implement some type of clinical integration program to circumvent the price-fixing problem. My own experience is that's typically not a particularly viable alternative from a number of standpoints. For example, in working with one state attorney general, that state's antitrust bureau, simply put, we don't buy clinical integration under any circumstances. That might be something the Feds believe in, but don't bring us any type of clinically integrated network.

There are other problems with clinical integration, as well. It's expensive. There's always a question of whether the joint negotiations are ancillary to the program, just a number of issues that, at least from my standpoint, suggest that clinical integration is not the way to go.

Another question that arises sometimes with regard to PHOs is the question of whether with regard to physician prices the hospital can establish the physician prices, ensuring that the physicians play no part in that. There are two business review letters from Justice suggesting that that might be the case. Both the letters are old. There's a 1983 letter to HCA and a 1987, I think, letter to North Mississippi Health Services, both of which involve PPOs set up by the hospital in which the hospitals or a subsidiary of the hospital established the physician fees.

Interestingly, if you talk to the agency people about this question, you

won't always get a consistent answer. And there are reasons for this. It's not because there's any philosophical or theoretical disagreement, but I hate to keep saying this, because everybody says it with regard to antitrust, but the analysis has to be very fact-specific.

Another issue that can arise frequently in a PHO, looking again at the physician component of it, is the over-inclusiveness problem. In other words, the PHO simply having too large a percentage of physicians in the area as members. And this typically is a problem because with regard to a lot of PHOs, the PHO is simply open to every doctor on the medical staff. And there are political as well as business reasons for this.

Politically, it's extremely difficult for a hospital to limit the physician membership in its PHO and in a number of cases, of course, the physicians that are included are needed. Where the PHO is over-inclusive, the question of exclusivity becomes particularly important. If you have a large participation percentage and the PHO physician component is either implicitly or explicitly exclusive: number one, there's a market power problem; number two, there may be an entry barrier problem as far as other networks coming into the market or expanding; and there may even be some type of group boycott problem if there's an understanding or an agreement among the physicians not to participate in other MCOs or other networks that come into the market.

On the other hand, exclusion of providers by a PHO, just like exclusion

of providers from any network typically, typically is not a problem. In fact, usually the problem, as I've suggested before, is exactly the opposite, the over-inclusiveness problem. And, in fact, it's hard to imagine an antitrust problem resulting from a provider exclusion, unless in some sense membership in the PHO or the PHO itself is in effect an essential facility and even if it is, if the physician market is still competitive, there shouldn't be a problem anyway.

There are a couple of cases that have discussed provider exclusion from PHOs, and all have reached the same conclusion, and that is, number one, the rule of reason applies, and number two, in the facts there, the exclusion was lawful.

I should be remiss if I don't focus also on hospitals and some horizontal issues that can arise with regard to them, although typically there are few, if any, horizontal problems, unless you're dealing with a multi-hospital PHO or a so-called super-PHO. And, in fact, there's an FTC investigation of one of those going on right now, so it is an issue that you have to look at.

And, again, the issue is the price-fixing issue and the same antitrust rules apply here as apply to the physicians or a physician-controlled network, but if you do have competing multiple hospitals as PHO members, you certainly have to consider the price-fixing issue.

Vertical issues. As I mentioned before, I'm really not -- the vertical issues may be the more interesting from an academic standpoint, but at least in my practice and in the cases I've not seen them arise, but there certainly are some that

have arisen in a counseling context. I'll just mention the ones that I've seen. Number one is the time problem between hospital services and physician services. In other words, the hospital says we won't sell you hospital services unless you purchase our PHO physician services, can be a problem, but also it's a rare occurrence. Usually the situation is if you want to contract with the PHO itself you have to purchase both the hospital and the physician services, but the hospital's willing to sell you hospital services outside the context of the PHO, and if it does, there shouldn't be an antitrust problem.

Another issue that's very similar that can come up is the hospital tying problem in the context of a multi-hospital PHO. The PHO that has a number of hospitals tells customers, if you want to contract with any of our hospitals, you've got to contract with all of them. And, again, if that's done only through the PHO, it probably shouldn't be a problem, as long as those hospitals that remain are willing to deal individually outside the PHO.

Intra-network referral requirements that typically arise in a PHO. One requirement is that referrals of PHO patients by PHO physicians be to other PHO participants. And there are obviously pro-competitive and efficiency justifications for doing that, but in very narrow circumstances, there can be foreclosure effects. It's at least an issue in counseling you have to examine.

There may be exclusivity requirements preventing physicians from joining other networks, sort of what we talked about before. And there, there can be

foreclosure effects both in the market for networks, other networks have trouble getting started or expanding, and there can be foreclosure effects in the hospital services market, because depending on the market power of the PHO components, other hospitals are foreclosed from referrals.

Now, let me talk a little bit about the women's hospital situation down in Baton Rouge. As I set out the facts here, I'm going to give you the government story, because the government spun a very interesting story as to what the situation was here. And some of the government facts I agree with; others of the government facts I don't particularly agree with.

The case centered around a hospital -- an OB/GYN specialty hospital in Baton Rouge, Louisiana called Women's Hospital. OB/GYN only, highly respected, pretty good size. And according to the government, the hospital had monopoly power in in-patient OB/GYN services. Every OB/GYN in Baton Rouge had privileges in Women's Hospital. For a number of years, it was the only -- it was a literal monopolist or a literal monopoly in the sense that it was the only hospital in the area that offered OB services.

And all of a sudden, another hospital in town decided to open up a small OB service itself. And according to the government, this just scared the bejeebers out of Women's Hospital, and so Women's Hospital went into action and took several anticompetitive actions to try to hamper the other hospital from opening an OB service.

And generally, according to the government, it did two things. This other hospital also was vertically integrated and had a large MCO subsidiary. And, so according to the government, Women's went to the other hospital and said if you all will not open your OB/GYN service we will increase the discount we give you when your subscribers use Women's Hospital. According to the government, that strategy failed, and so the next thing Women's Hospital did was it formed a PHO. And the rationale for the PHO was the loyalty rationale, that is, an effort to keep Women's staff members from seeking privileges from the new hospital.

And, according to the government, Women's did several things. First, it tied its hospital services and physician services. In other words, to purchase hospital services from Women's Hospital, you had to purchase them through the PHO and you had to take all the PHO physicians as well.

Secondly, Women's Hospital came up with a very attractive fee schedule for its physicians. It used that fee schedule in negotiating prices with third-party payers in an effort to make the PHO so attractive that physicians would contract only through the PHO. If they contracted through the PHO then they had to admit t Women's Hospital.

So, anyway, here you had the usual horizontal price-fixing problem. You had a potential tying arrangement; you had a potential market allocation agreement; and you had at least arguably some effort to monopolize or attempt to monopolize the market for OB services. And the government in what I thought was

an interesting but somewhat misdirected complaint charged the PHO and the hospital with horizontal price-fixing, and then it charged the hospital with attempting to maintain a monopoly. And of course, there's some question whether that even constitutes a violation. You might take a look at the recent Lapage's opinion on that. And it charged the hospital with actually monopolizing in-patient, OB/GYN services in Baton Rouge.

And the case, as all these cases have been, was subsequently settled by a consent decree. But as PHO cases go, my own feeling is that the Women's case probably presents as great a variety of alleged bad acts or violations as any other, and it goes beyond the usual horizontal price-fixing issue, and so I think it's a particularly interesting example.

(Applause).

MS. OVERTON: Thank you, Jeff. Next we'll have a presentation from Meg Guerin-Calvert.

MS. GUERIN-CALVERT: And I'm not as tall as Jeff is. Let me see if I can work the technology here.

It's a great honor to be invited to be here today. I particularly want to take an opportunity to thank Leslie and Matthew for kind of giving me an overview of what some of the other speakers were going to be addressing. But I also wanted to say that I think this particular session and some of the sessions that are coming up, I particularly want to commend the FTC and the Department of Justice for focusing on

factual development. Because I think as Jeff indicated, there have been a number of investigations and cases and business review letters that have involved PHOs. In general, those have been the cases, I think as Jeff very accurately described, that have the best possible fact patterns from an enforcement perspective.

They are ones where there are relatively few issues with respect to the extent of other competitive alternatives. They are ones that in general, if you look back over all the cases, have much more in the way of exclusionary practices involved. More significantly, they are ones where in a number of areas the PHO that has come under scrutiny has really not met basic elements of financial integration or clinical integration and have been more raising issues of possibility of pricing coordination.

And I think while those provide an enforcement record, they really provide relatively little insight into the issues that I think these hearings are addressing, which is really vital -- which is how are PHOs in similar contracting arrangements actually working in the marketplace; what are the significant business justifications that people are entering into these arrangements for; what are the alternative mechanisms that they have considered and possibly rejected because a PHO format may be providing a better or more systematic approach to accomplishing certain objectives.

And then as I think with all issues that these hearings have addressed, there has been a remarkable amount of change in this sector, as in all others. So, taking a quick snapshot assessment of two or three years ago as to what PHOs were providing as a contracting mechanism doesn't necessarily provide you insight into

what's going on this year or next year or five years from now.

And I think in particular I'm looking forward very much to hearing the other panelists talk about those elements of why they have been involved in PHO, what they see the gains, whether it's quality, whether it's efficiencies, whether or not it's improvements.

I think my perspective as an economist is really to say that a PHO is just simply -- it's a contracting arrangement. As Jeff indicated, of a majority it has some vertical arrangements, at least between a hospital, a single hospital, and a group of physicians. It has other associated possible contracting arrangements. It has, even between those two levels in a number of PHO contexts, we see a top-level, namely managed care, where the organization decides to become much more fully integrated. Perhaps it takes on full-risk contracting, so not just be a provider of hospital services and physician services, but also be essentially a provider of insurance services and so involving all of the risk and intended skills.

And while I know that Kaiser does not regard itself really as a PHO, to an economist, it essentially is. It is a fully integrated health plan, all the way down to enrollees, system. And, you know, I think one of the things that we should all keep in mind is most people regard, in general, Kaiser to have been very successful at what it has accomplished. And, so, in terms of the business justification and the rationale for their particular contractual arrangements, even though those are within the context of employee agreements, they serve as a good benchmark or perspective to be thinking

about what hospitals and providers who are otherwise more independent might be trying to accomplish.

I say it's a subset of possible contracting arrangements, because as we all know, there are a variety of contracting arrangements that have been developed over time, many of which exist simultaneously in a market. For example, you could have a marketplace, particularly in an urban area, where one or more hospitals may be involved in PHOs, many of which may be open model PHOs and not exclusive PHOs, so there can indeed be overlap among some of the physicians. At the same time, you could have IPAs, within that area, with contracting mechanism, again, at the physician level contracting with managed care organizations and hence having arrangements that involve some or more hospitals in that managed care organization's networks.

And, lastly, what has developed in some marketplaces, some plans have used it more successfully than others, is direct contracting. It does not necessarily fit all elements, but there are certainly some managed care plans who have managed to enter markets through direct contracting, even for HMO, with physicians. So, we have seen not a single model but a coexistence of a number of models. I think that's worth keeping in mind. Some of those models have risen or fallen, but all of them involve some element of vertical arrangements and some element of risk-sharing.

My third point there is they have involved different stages or types of integration. You can think of it in terms of integration, in terms of any kind of relationship between the managed care level and the hospital level. The hospital level

and the physician level as well as integration among hospitals and among physicians into larger networks.

And then the types can include, as Jeff mentioned, financial integration, and increasing clinical integration. That is an area where I think Jeff correctly points out that state agencies, and also the Federal agencies, to some extent, have been very, very skeptical about the benefits of clinical integration. I think, in part, as I'll get into a little bit later, some of that is: A) because it's new, it does not necessarily show up immediately in the form of a dollar cost savings, it tends to be much more so very, very significant investments in best practices, in protocols, and in development of MIS or IT systems. And, so, the payoffs tend to be further down the road. And I think that affects the types of marketplace outcomes.

I'll also touch very briefly, since I think Jeff has covered it very well, on the antitrust issues. In terms of background trends, how I think about PHOs, and I think the other panelists will be speaking to this in much greater detail, is the background trends that have occurred over the last five to ten years have affected the development, the expansion, in some respects the contraction and the evolution of PHOs as a contracting mechanism.

As we all know, managed care has been through very substantial evolution: the rise of HMOs; some backlash on the part of consumers; and now much more focus on PPOs and broader networks. That, I think, kind of follows, as well, the range of trends on the PHO side, as a number of hospital and physician networks

moved into full-risk capitated contracts. Some did it successfully. Many did not do it successfully, for a whole variety of reasons. And now you see relatively fewer organizations being involved in full-risk contracting.

I was quite interested to see last week, or actually at the beginning of this week, Modern Health Care reported that Kaiser in the Washington area is actually thinking of offering more open networks, moving away from a pure HMO model, so as to attract more enrollees, because nationwide HMO enrollment has experienced a very substantial decline from its previous peaks. And, so, that's, I think, a trend that is mirrored in what we see on the PHO side.

Similarly, on the physician network we have seen broader networks, the development of a lot of large nationwide management systems. Those, again, have been tested and tried as an alternative to improve quality, improve cost containment. Some have had some success; a lot have not. And that, again, I think is reflective of the difficulties that PHOs have in terms of organizing the physician component, as well as integrating it up and making it work well with a hospital component. Quality and cost containment I think basically speak for themselves, but I think as Jeff mentioned, where I think some of the new areas that will be interesting to focus on is what exactly are PHOs looking at and focusing on with respect to disease, management systems, case management systems, development of data bases, and best practices protocols.

This is an area -- there is a lot written on in the literature and a lot of focus on the idea that by pooling together larger groups of physicians with hospitals

and somewhat larger groups of hospitals, you may be able to attain the size of data bases to contractual arrangements that you really can't do with much looser affiliations. Other marketplace mechanisms have not developed and have not caused those kinds of investments to occur. So, I think that will be something to focus on. And, as well, there are some integrated systems along the looser version of the Kaiser model.

Let me spend a couple of minutes -- there's a -- let me just skip ahead here -- a very large number of websites that have all sorts of information on PHOs. This particular one I don't assert the quality of. It's one among many I found, and it's advantage was it had a number of nice spreadsheets -- as an economist, I like spreadsheets -- that gave information. The one that was way too big to put up here is a very detailed listing for the year 2002 of the identity of all the PHOs in the country organized by state, very large number of PHOs.

But to give you an idea of the kind of information that is out there, this particular site basically focuses on, in general, what's the distribution of types of members that are in the PHO. And basically what it shows is that the largest proportion -- currently -- this is 2001 data, is in discounted fee-for-service; a relatively comparable number are in full-risk, partial or global cap or in partial risk system, and that amount combined together is still somewhat less than the fee-for-service.

So, again, it gives you a perspective that even on this dimension, you have three different types of financial risk arrangements that the PHO might be

entering into. And on the full-risk side, in my experience, that is an area where increasingly PHOs are moving out of and more so into partial risk and also trying to grapple with the discounted fee-for-service model.

Another area, this is again, kind of building a little bit on what Jeff said. It gives you an idea that there is a range of types of PHOs. And as I mentioned at the outset, this reflects a lot of different contracting models that different organizations have chosen. Of a majority, about half are simple PHO models, about 10 percent are what Jeff had referred to, the super-PHO, larger number of hospitals and physicians, and then they show a wide variety of other models as to whether or not it's just an IPA MSO kind of arrangement or different kinds of contracting.

And, again, what this basically implies is that we have different kinds of contractual arrangements that might exist between the managed care level, the insurance product level, the hospital level, and the physician level. And at least at the hospital level and potentially at the physician level, alternative models that might be considered. Let me just go back up.

And, you know, I think as I mentioned, part of what is going on is that you have simultaneously with these different models a variety of trends in terms of the scope of their financial integration, the amount of their full risk contracting, the trends that are pushing them in particular directions. But I do think the most interesting one to watch, because I think it affects the quality outcomes of care, is what PHOs are attempting to do now with clinical integration. I think this is, as Jeff mentions, an area

that is regarded with some skepticism, but I think in terms of business justification is what is driving a lot.

Let me try to supplement a little bit what Jeff had to say about the antitrust issues, because I think he really covered the big picture issues and the areas where the most significant case activity has been. I would regard it really as two related issues that I would like to bring up. One is at the network formation level. I think -- my sense of looking at the health policy statements, looking at the various business review letters and so on -- not surprisingly, how PHO formation and activities have been regarded is really in the context of joint venture analysis.

I think that's the appropriate analysis, the appropriate framework to be thinking about it in, and I think there are, as Jeff mentioned, a couple of the issues that are really important in that formation is is it an inclusive network, and one that is basically open and permits a large number of alternatives, or is it in some way, shape or form an exclusionary network. I think in both of those cases, the inclusion versus the exclusion and the joint venture aspect, it is very critical that the parties to the formation really set out very well what it is that they're hoping to accomplish with the particular model, what systems and mechanisms they have set up, both contractually and in terms of enforcement.

And I think if you look at the PHO contracts that are out there, these are extraordinarily complex documents. And I think that in and of itself gives us all some insight in the task that a PHO is attempting to accomplish. If you look at these

contracts, they have in them entire management systems as to how the relationships at each level and between level are going to be governed, how the financial aspects are going to be dealt with, who specifically is going to bearing what risks, who is going to be covering losses, who is not, and that's where a lot of litigation has gone on between the different levels, when there have been significant losses.

But also, there's a huge amount of the contracting that is focusing on the development of practices, protocols, and development of data. There's a whole lot more in these contracts other than just the establishment of the fee schedules and the negotiations with the managed care plans. And, so, I think in and of themselves they are very rich documents for showing how, within an organization, there is an effort to try to replicate, in essence, the elements of what Kaiser has accomplished, through much more significant contracting.

I think in terms of marketplace competition, putting PHOs and other contracting arrangements between physicians and hospitals and managed care plans, such as IPAs and direct, is again to look at in examining any particular situation whether or not the existence of a PHO still permits and allows the co-existence of other kinds of structures and arrangements and looking to see why these other arrangements continue to exist and why they're evolving.

I think this gives an idea that there are more -- there's more than one alternative mechanism that entities can approach a given set of problems with, and I think what will be particularly important to watch is -- that my sense is from reading

the literature -- is PHOs have focused somewhat more so recently on the quality issues and the quality of care issues; while on the managed care side, there has been more focus on the delivery at a specific price of a set of services to the enrollees.

And, again, those are two different business models, not to say one is better than the other, but as a result, there may be some conflict and some tension between the managed care plans and the PHOs. If the effort to achieve one particular result, for example, on the managed care side, may not either in timing or in substance allow the alternative approach to proceed or the reverse can happen as well. And I think particularly as with new contracting mechanisms, we'll probably be going through some shake-out system.

But as Jeff mentioned, I think something that we do need to keep an eye on is the entry and expansion possibilities. There are going to be certainly some circumstances in which in terms of having the particular structure of the physician network and the particular structure of the hospital network that one will have to look at very carefully and try to demonstrate that it does not preclude the entry or the expansion of alternative systems or alternative choices by managed care plans.

And I think that is why when we see hundreds of PHOs out there, the vast majority of them have not raised significant antitrust issues, because they're existing in marketplaces where the plans have a lot of alternatives, and where the physicians have a lot of alternatives. As a result, the patients have a number of alternatives.

Jeff covered the horizontal issues, so let me just sum up with what I would view as the bottom line. I think that is probably one of the most important areas for us to be looking at. And, again, as I mentioned at the outset, I commend the FTC and the DOJ for focusing on the factual developments in contracting arrangements that are going on among hospitals and physicians in particular, but also between those entities and the health plans, because I think this is the response that we're seeing to consumer demands for more open networks, PPO-type networks, as opposed to HMO and for efforts to try substantially to change the quality of care, improve the quality of outcomes.

It's going to be interesting, and I look forward to hearing more about how compatible these various alternatives are with each other, which ones have come and gone, and which ones are continuing to survive. And, as a result then, what are the comparative advantages of different models for achieving different goals. It may well be that certain models are not best at accomplishing a given goal, but that doesn't mean they aren't achieving good outcomes.

And then in terms of competitive effects. I think just to echo Jeff, I think the key thing is looking at what is the business justification for the particular model, the particular practices, and looking at both. Are there significant concerns at the vertical level, that is, is it exclusionary of other competitors and also of the horizontal effects and then obviously in terms of the competitive effects in the marketplace. Is it resulting in substantially higher prices than would otherwise have

been attained for the same quality of care. I think in particular looking at what is it that is attempting to be accomplished through this contracting mechanism.

(Applause).

MS. OVERTON: Thank you, Meg. Next we'll have presentation from Dr. Serdar Dalkir from MRCA.

DR. DALKIR: Good morning. Today I will talk about whether PHOs can accomplish anticompetitive vertical restraints. This presentation was prepared by myself and David Eisenstadt. David couldn't be here today. Without him, this presentation wouldn't have been possible.

MCRA is a consulting and research firm. We are both with MCRA. We are in Washington, DC. We have worked with clients in the health care sector, both providers and insurers. David and I are industrial organization economists. David is a former Department of Justice Antitrust Economist, so therefore, we are not lawyers and as a general matter, we cannot speak to purely legal issues and obviously nothing in this presentation constitutes legal advice.

Previous speakers told us about the trends and different types of PHOs. I will try to bring to your attention some economic models that people might use, the analysts might use to understand and interpret facts and trends. We're starting from hospital-physician complementarity. Hospitals and physicians are usually complements, they go together. Most antitrust practitioners would conclude that the formation of a PHO is pro-competitive because of this complementarity between the

two.

The joint pricing of two complements, each with some market power, generally improves consumer welfare. The package price for hospital-physician services will usually be lower after the formation of a PHO. Therefore, this should probably be the presumptive rule to evaluate PHOs, but there are or may be exceptions.

Anticompetitive vertical restraints in economics, industrial organization parlance, usually fall into one of five categories. These are facilitating horizontal collusion; erecting entry barriers or raising rivals' costs; price discrimination; evading regulation; and, finally, reducing substitution away from a quasi-monopolized input.

I will try to explain briefly each of these points. The facilitating horizontal collusion, a hospital might want to foster price fixing or collusion among the doctors in return for rent splitting. Rent splitting could take several forms, which do not have to be explicit. They can cover cases such as a bond market rate payments by physicians for hospital space or services.

To erect entry barriers or raise rival's costs, a hospital could use a PHO to competitively disadvantage other hospitals. If the physician members of the PHO must contract exclusively through the PHO, competitive hospitals who depend on admissions from those physicians may be in a disadvantaged position.

To price discriminate through exclusion, one example would be the best hospital in a geographic area forming a PHO with the best physicians in the area

and bundling their services together to extract more consumer surplus from the payers. We covered this case in a previous session during these hearings.

To evade regulation or price regulation, a hospital could employee physicians and mark up their services to effectively evade price regulation, and admittedly this is closer to a -- this example is closer to a staff model than a PHO model.

Finally, to reduce substitution away from a quasi-monopolized input, I'm going to start by assuming the following: let's say the hospital has some market power but not a strict monopolist. Secondly, payers believe that they must contract with the hospital in order to sell their product. At the same time, buyers would like to substitute away from the hospital toward other hospitals.

To minimize substitution possibilities, the hospital may form a PHO and contract on an exclusive or semi-exclusive basis with member physicians. The hospital would or might offer payers contracts for the hospital conditional on those same payers contracting through the PHO. This type of tying of the hospital and physician services can limit physician use of less expensive hospitals.

In antitrust economics, this type of behavior is known as tying to reduce substitution away from the monopolized input. Competitor hospitals may also complain that this type of behavior is exclusionary.

Next I'd like to walk you through a rather simple model to demonstrate how this market power is created through this type of tying. In a nutshell, reducing

substitution away from the hospital reduces the elasticity of the derived payer demand for the hospital.

I didn't expect to see these characters, where I had written the formula, but nevertheless, let me point out that -- this is great.

MS. GUERIN-CALVERT: Economics is a black box.

DR. DALKIR: That's right. There's a positive direct relationship between what we call as economists the elasticity of substitution between hospitals and a given hospital's elasticity of demand by the payers. It's a direct positive relationship. If the elasticity of substitution goes up, the elasticity of input demand for that hospital also goes up.

So, in this graphic or graphic design, the first two characters, the black box and the check, I suppose is the elasticity of derived demand for the hospital, which equals the checkmark, the hospital's share in payers' cost, times the ambulance or the aid truck, which is elasticity of demand for all hospitals, plus one minus hospital share in payers' cost times the question mark, which is elasticity of substitution between the hospital and other hospitals.

And what I'd like you to remember from all this is there's a positive relationship between the question mark and the black box.

(Laughter).

DR. DALKIR: Here's a graphical demonstration of the relationship between the question mark and the black box. On the vertical axis is the price of

hospital services. On the horizontal axis is the quantity of hospital services. The blue line that you see is the initial demand for hospital services before a PHO is formed. After the PHO is formed and in this example reduces substitution to other hospitals, the effect of this reduced substitution is that the elasticity of substitution question mark between the hospitals is reduced, but since there's a positive relationship between the question mark and the black box, the black box is also reduced. In other words, demand for the hospitals becomes less elastic.

We show this by the red line, which tilts the blue line at its original equilibrium point. As a result, the hospital is able to price higher than before. Its price rises from P-not to P-one. And the quantity serviced is reduced from Q-not to Q-one.

What may be some general rules for the screening of PHOs employed by these models, PHO are more likely than not to be pro-competitive if a pure monopoly hospital combines with a single physician group, which also faces little or no competition in the area. Or, the hospital with little market power or no market power combines on a nonexclusive basis with a physician group.

This leaves only the intermediate market structures between, I guess, the monopoly and the no market power pro-competitive. For these intermediate market structures, the questions that may be asked are as follows. Is the relation between hospital and physicians exclusive? Do other hospitals complain about PHO's formation, and if they do, why? Thirdly, have payers complained about the hospital's rates and sought to substitute other hospitals? For example, have the payers

encouraged the doctors to obtain pricing from, or shift admissions to, competing hospitals?

Another question that may be asked for these market structures that are neither monopoly nor competition: does the hospital engage in other activities which reveal concern about substitution away from it? And, finally, have the doctors threatened to compete against the hospital, in actuality or potentiality?

This concludes my presentation. Thank you for your attention.

(Applause).

MS. OVERTON: Thank you, Serdar. Next we have John Marren.

MR. MARREN: People make jokes about lawyers. That was very good. You have to understand, my orientation in coming to this is somewhat different perhaps. I have -- how do I do this? I started out in health care, not as a lawyer, but as a tech in an emergency room and eventually became an assistant vice president in a hospital. Of course the president made all the decisions, so it was kind of like I had more control as a tech than I did at anything else. But then I spent the next 20 years as a health care lawyer and put together about over 100 IPAs, PHOs, et cetera, write -- and then found out I had to write joint venture or Copperweld type opinion letters, so I started having to learn something in antitrust. I have been involved in a number of kinds of things and teach a lot, but my orientation is really -- although with very few exceptions -- I have to start by saying if you've seen one PHO you've seen one PHO. I really appreciate the opportunity to talk today and I really appreciate the fact the FTC

and DOJ are taking a factual analysis and looking at this, because there really is no way to over-generalize.

In listening to Jeff's presentation and the other presentations, it's important to me to realize that most of the PHOs I deal with, or almost all of them, have no market power and they have no exclusivity and really are focused on medical management. So, I suspect that there are -- we wouldn't be having these discussions if there weren't other types of organizations out there who were doing something differently.

But we have to put this in context. When I started first putting together health plans in the mid '80s, the HMOs and PPOs, we would go around and literally medical staffs would throw things at you because you were talking about some kind of, depending on their orientation, communist or socialist type program. But that generation of physician isn't around anymore. The doctors that are mainstream doctors now that are practicing in America have grown up with managed care. So, when I talk to doctors now, physicians especially, and hospitals, they're really much more oriented towards a managed care and a quality orientation. So my bias is that I truly believe that networks ultimately can prevail and do some good things.

But in terms of understanding this, you know, you have to think about the context of the market, and the market was the Federal HMO Act and creating IPAs and the ability to spread risk amongst different networks of physicians particularly. And we got -- we came up with the creation of the IPA. The PHO

evolved because hospitals wanted to have an IPA and needed to have some kind of input. Doctors don't self-organize very well. So, hospitals became a focal point for pulling together physicians who were more or less oriented towards them. But again, I don't know of any -- except for a couple of very unusual circumstances in very rural areas -- doctors who are completely exclusive to either one PHO or IPA, or who are only contracting through the IPA or the PHO for services or for patients.

ERISA also came into play in the sense that it removed the ability to sort of bring action against a lot of plans. The evolution is that all forms of managed care came along. In our market, the Chicago Land market, there's really a lot more PPO type activity or discounted fee-for-service than there really is pure HMO or managed care type organizations and contracts.

The evolution continued and we saw much more focus on the typical managed care type issues, and if you think about it, these organizations really in the old days had no data. We didn't have really computerized type systems that we have today. We didn't really -- people really didn't know what was going on. There was no way to really track things, and doctors like Ernie Weis were really visiting with their colleagues and trying to talk to them about a different way of practicing medicine. And there was a lot of conflict between the plans and the doctors.

There has been a lot of dialogue about the problems with managed care. People on the managed care side or health plan side would probably say there's been a lot of problems because doctors have not been very cooperative with respect to

managed care. I personally think there's probably an overall design flaw, but what we've seen is legislators doing what I call anti-managed care legislation. And so when we think about evaluating PHOs or physician networks or hospital networks, you have to think about in terms of -- I think about it in terms of the fact that these people are really trying to protect patients in a lot of ways. We can't just think about them from a pure antitrust perspective in a sense of trying to fix fees or do things that are anticompetitive. Ultimately, especially with respect to physicians, these are people who are caring for patients day in and day out.

We've seen lots of wrongs in managed care. PHOs, networks, medical societies, et cetera, have lobbied to eliminate all products, clauses, prohibition of de-participation determinations based on patient advocacy. Lots of things have taken place in the evolution of what we see in managed care. We've had attorneys general and DOI (Department of Insurance) investigations, focus industry-wide regulations and changes to make things a little bit fairer with respect to how managed care is going to -- plays out.

Lots of court findings about various issues in managed care. Lots of, you know, things that have happened to the managed care industry based on perhaps bad management or bad design. And recently we've had what's going on in Florida and the application of Rico to some of the things that have happened in managed care.

I'm not here to bash health plans or managed care organizations. Again, I've put together a number of them. But I really do believe that there is a role

for a PHO or for a network. Again, this isn't to say that people -- competitors couldn't get together and do something in restrain of trade, but the real focus that we should be thinking about is organizing providers for purposes of looking at quality. And, again, my orientation is I see much more work in that area and I see physicians much more willing to focus on clinical efficiencies, clinical integration quality.

So, from my attitude, the best-case scenario is continue to develop PHOs, IPA and OWAs (other weird arrangements) again, focusing on integration. And if you look at -- again, if you look at one PHO, you look at one PHO. But, again, I think that most of the folks that are still around and still doing this stuff are really in the business of managing medical care, looking at disease states. I think of them not as sort of leveraging the marketplace to increase cost, increase price. I look at them as people who are focused in many ways on picking out various disease states and then managing them to reduce costs, to reduce overuse, under-use and misuse. And I think that's a significant issue.

So, when I think about network positions, I'm thinking about folks who get together, negotiate contracts, primarily on a risk basis, but maybe in other cases as well and other scenarios as well, but then using the data that they have to look at how patients are treated and to enhance quality and to, again, eliminate or reduce overuse, under-use and misuse.

What are the challenges to real clinical integration in this country? I don't think -- I think first of all, the cost of clinical integration is significant, as was

mentioned before. Who is going to incent physicians to really change the way they practice? What's another challenge? Will payers deal with clinically integrated networks? If we have -- can we set up systems between payers and providers where there's a sufficient exchange of data so the providers can actually manage the patients that they have, take a look at different disease states and reduce costs.

I'm going to touch very briefly -- well, I was invited to speak because I represent an advocate, you know, in a lawsuit with Blue Cross. Brad Buxton has the last word today, so that's unfortunate, but Brad and I go way back. It's a very small town, Chicago. Advocate's PHO, AHP, attempted to take its financially and clinically integrated network of physicians and negotiate with Blue Cross of Illinois on behalf of about 1,700 of those physicians.

Blue Cross -- no real negotiation ever took place. Blue Cross filed a lawsuit claiming price fixing, tying and group boycott. I won't comment on the lawsuit or its purpose. I think if you really want to know something about the lawsuit, you should probably pull the file and take a look at it, and you'll -- I think you'll get your own set -- you can look at our answer and our motion to dismiss and you can get your own sense about it. But I'm not here to really talk too much about that.

The end result is -- what really happened is Blue Cross stopped making periodic payments to Advocate hospitals in the context of this disagreement. And that's really what we ended up litigating more than anything else. We're in court talking about why Advocate should get paid, why Blue Cross should pay them.

So, we don't think they really prosecuted the antitrust case. I don't know that it was -- Brad can disagree with me and probably will -- but I don't think it was really about an antitrust issue, but again, if you're really interested in that case, I would pull the file and you can take a look at it and see what it has to say.

Essentially, what happened was both sides arrived at an HMO contract. AHP never really negotiated on behalf of the physicians, it was never really -- got very far in the process and was not allowed to negotiate for clinically integrated arrangement for fee-for-service patients. From my perspective, if -- I won't talk about Blue Cross anymore. Let's just talk about any plan. If a plan is willing to sit down and talk with an integrated network and discuss the capacity for exchanging information and then pay money to incentivize the physicians to participate in real disease state management, real quality control and real time, I think we're going to have a much better model.

I think that's really the way to go. It isn't about just price; it's about information; it's about managing patients; it's about a lot of different things. And it's unfortunate that it didn't happen in this case, but trusting Blue Cross' commitment to quality, I'm certain that at some point in the future we'll be able to work out some sort of arrangement.

That's really about all I have to say. And, again, the concept is I look at PHOs as the ones that are still around, the ones that haven't, you know, gone bankrupt or fallen by the wayside of lost their reason for being are struggling to do

medical management, struggling to do quality and control and really trying to do something, you know, on behalf of the patients, on behalf of the providers.

So, again, I don't see a lot of exclusive PHOs, it just might be my experience. And I think that's -- that we should be encouraging networking physicians, we should be encouraging payers and providers to work together to exchange data, and we should be looking at overuse, under-use and misuse. Thank you.

(Applause).

MS. OVERTON: Thank you, John. Next we'll have Dr. Ernie Weis from Advocate Health Partners.

DR. WEIS: Good morning. I'd like to review a couple of items from my bio, primarily to indicate the justification for my being here this morning and having the privilege of addressing you. Since 2001, I have been the Vice President of Managed Care for Advocate Health Care and the Chief Executive of Advocate Health Partners, a care management and managed care contracting joint venture between Advocate and the doctors on the medical staffs of its hospitals.

From '98 to 2001, I was Chief Executive of Advocate Health Centers, a community-based medical practice that provides a full range of primary care services, specialty care and support services, treating more than 200,000 patients -- that number always sticks in my throat -- each year in 19 locations throughout Metropolitan Chicago.

Previously, I've held executive positions with numerous managed care organizations in Chicago. And prior to that I practiced pediatrics for 20 years in the same community in the Chicago Land area. I have an M.D. degree from the University of Illinois College of Medicine. I completed my internship and residency at Michael Reese Hospital and Medical Center in Chicago. And in 1983 I was awarded a Master of Management Degree from Northwestern University, Kellogg Graduate School of Management. And I'm a fellow of the American Academy of Pediatrics. Well, enough about me.

Over the years, the need to streamline operations and create efficiencies in the Chicago Metropolitan health provider market became apparent. Several health systems formed, including Advocate Health Care Network through the merger of the Evangelical Health System and the Lutheran General Health System in 1995.

In order to facilitate managed care contracting and financial risk management associated with a classic capitated model, all Advocate hospitals develop PHO models over time. Ultimately, the PHOs became linked together as Advocate Health Partners.

AHP, as it exists today, consists of eight PHO joint ventures, including 2,400 independently practicing physicians and eight Advocate hospitals. These hospitals comprise the core of the Advocate Health Care Network, a faith-based, non-profit integrated delivery system with an intense focus on providing high quality, efficient health care. It has consistently been ranked among the nation's top ten

integrated health care systems for the last five years. It contains nearly 3,000 inpatient beds and includes small community-based facilities and large tertiary care medical centers, serving diverse populations in the city and the suburbs.

It includes four level-one, highest level in Chicago, trauma centers, out of the total of eight in the Chicago Metropolitan area. Three teaching hospitals training over 600 residents and fellows, more than any other non-university hospital in the state. Also, it includes two of the four major children's hospitals in Chicago and four level three, which is the highest level, neonatal intensive care centers and high-risk pregnancy centers.

In addition to the independently practicing physicians, Advocate Health Partners represents three multi-specialty group practices, which total approximately 600 physicians, including Advocate Medical Group at Lutheran General, the Advocate Health Centers I referred to previously and the Dryer Medical Clinic in Aurora, Illinois.

The slide that you can see on the board represents the business structure, and we have another one representing the financial structure of AHP. And since this is way too complicated for a physician, I've asked my colleague, Thomas Babbo, Advocate's in-house counsel, to walk you through these.

Tom?

MR. BABBO: Thanks, Ernie. Yeah, this is kind of a busy slide, I recognize, so I'll just take a few minutes here to walk through it. Basically what this

slide represents are sort of three areas of relationships within Advocate Health Partners. At the top it describes the governance of Advocate Health Partners. Advocate Health Partners is composed, as Ernie mentioned, of a number of PHOs, as the PHO member, and the system member, which is the Advocate Health Care Network.

In terms of board seats and voting, votes are -- there are -- you can see the numbers next to each of those balloons. Each PHO gets one seat on the board. The Advocate Health Care Network has those seats on the -- two for the Dryer Clinic, two for Advocate Health Centers, five for the hospital and two for Advocate Medical Group. Votes are actually then given to the PHOs based on tens of thousands of covered lives. So, that's the governance relationship. So, you have an evenly balanced relationship between the network and the PHOs.

And then you have within that organization of Advocate Health Partners that board, plus you have a consolidated finance committee, consolidated utilization management committee and a consolidated quality improvement committee. The operations of the -- or what's called the back office of Advocate Health Partners, in terms of managing financial risk is performed through a vendor arrangement with an organization called Health Partners Operations, which provides claim payment services.

At the bottom, you can see the provider relationships. It represents the same groups that are up above in the governance role, but here it reflects that the

relationship by contract, as members participating in Advocate Health Partners managed care contracts.

This next slide represents how Advocate Health Partners is able to financially integrate this very large network of providers. Advocate Health Partners contracts with managed care companies for full risk contracts. It obtains the capitated revenue into its general ledger and establishes member revenue funds for each PHO. Those PHOs, then need to determine how to pay their provider, you know, the physician and hospital expenses through those contracts by developing, in collaboration with Advocate Health Partners, what's called the member financial model. The member financial model then is the blueprint by which the funds from those capitated contracts are paid out to the hospitals, physicians and other ancillary providers.

If, as one would hope, you're managing your expenses well, you would have excess revenue over expense from your capitated contracts, which is then, by determination by the Advocate Health Partners Board of Directors, distributed out to each PHO, who are then able to distribute any surplus that's remaining, as they're non-profits, to the members of their organizations.

MR. WEIS: By the way, the Advocate Health Partners patient population, capitated lives now represents about 400,000 members, patients. In addition to financial integrating, it was also necessary to clinically integrate the AHP providers to create greater efficiencies and to assure against the potential for a

reduction in quality caused by or related to the management of utilization to lower the cost of care.

These systems include AHP's utilization management program, whose policies and procedures are mandatory for all AHP physicians. AHP's utilization management program routinely receives accolades for managed care organizations, most of which have been so confident in our program that they have delegated their own UM to AHP. Equally significant, clinical integration is gained through AHP's quality improvement program, with it's coordination and sponsorship of Advocate Health Care Network's clinical excellence initiatives, measurement and analysis of clinical outcomes in patient satisfaction data, peer review, and credentialing activities.

AHP's use of Advocate's NCQA-accredited credentials verification office has brought about managed care organization delegation to AHP of this function, as well. AHP is deeply committed to Advocate Health Care Network's quality initiatives, furthering Advocate's strategic priorities of clinical excellence, patient safety, and clinical quality.

By the way, of the 200,000 capitated -- 400,000 capitated lives that I mentioned, 40 percent of those come from Blue Cross's HMO Illinois, which has consistently awarded Advocate Health Partners its highest level of recognition for its achievement of quality initiatives under HMO Illinois.

Other care innovations that have taken hold across Advocate due to AHP are the use of hospital lists covering about 165,000 of those capitated lives at

several hospitals throughout the metropolitan area, pharmacists led anti-coagulation clinics, an extensive diabetes management program, an asthma program, and a congestive heart failure care management program with over 700 enrolled patients.

Although Advocate Health Partners was designed from its inception to operate within the context of capitated medicine, managed care organizations have frequently approached AHP for more than just HMO contracts. MCOs seeking entree into the Chicago Metropolitan network contact AHP to establish a provider network for both their HMO and PPO products. Established managed care organizations with existing capitated contracts with AHP tend to seek contracts for their fee-for-service products, as well, citing both an administrative efficiency and recognized quality of AHP physicians.

Historically, AHP's fee-for-service contracting preceded along routine messenger model lines. Although spillover efficiencies were certainly present, AHP recognizes -- requires all of its network physicians to participate in its capitated managed care contracts and thereby in all AHP quality improvement and UM programs. It has been clearly evident in the hospitals historical utilization patterns that sites with capitation at the time of formation of Advocate in January of 1995 had lower average length of stays for Medicare and non-capitated patients than other sites. As capitation moved to all sites via AHP, this gap disappeared. As such, the managed care organizations that hold with messenger model fee-for-service contracts with AHP's network of physicians have up to now reaped the clinical quality and efficiency

benefits of AHP physicians without compensating AHP in the exchange.

Health care in both the Chicago Metropolitan area and in the U.S. in general is in a state of financial crisis. There has been shrinking reimbursement from Medicare and Medicaid, ever increasing costs for new technology and treatments, and, in the absence of tort reform, skyrocketing jury verdicts, which in turn have caused a drastic shrinkage in the professional liability insurance market and exponential increases in premiums.

Several weeks ago, Illinois State Medical Insurance System, the largest among the handful of remaining physician malpractice insurers in Illinois, announced that it would raise its base premiums by 35 percent. This is on top of the huge premium increases for crucial specialists like anesthesia, OB/GYN, and neurosurgery.

AHP, its physicians, and the hospitals of the Advocate Health Care Network are convinced that group contracting, via financially and clinically integrated network of providers, offers a creative solution to these problems, whereby we can create the kinds of efficiencies necessary to fulfill our mission, to provide high quality medicine to all of our patients, whether in low income, inter-city neighborhoods or affluent suburbs at a reimbursement level that allows us to cover our ever increasing costs and invest in capital improvements.

A word about the negotiations with Blue Cross, which John alluded to and I'm sure Brad will respond to, as well. With the clinical integration of AHP doctors developed through AHP's capitated experience and because of the clear

evidence from AHP's experience in messenger model fee-for-service contracts, that managed care organizations value this integration, AHP decided to seek a clinically integrated physician PPO contract from Blue Cross/Blue Shield of Illinois, during its recent negotiations.

In AHP's view, a group physician PPO contract would have maximized for Blue Cross' fee-for-service patients the quality and efficiency benefits of AHP's clinically integrated network.

Given that Blue Cross has historically demonstrated commitment to clinical metrics and Blue Cross has repeatedly indicated their interest in linking increased reimbursement to improved outcomes as demonstrating value to their customers. However, Blue Cross historically contracted only with individual physician practices and not integrated groups.

Through this contracting strategy, Blue Cross had over time developed the ability to contract on a take-it-or-leave-it basis with its large network of individual physicians. In AHP's physician PPO proposal to Blue Cross, it sought to collaborate with Blue Cross to create a demonstration project to incorporate clinical integration within the design of the business arrangement.

This proposal, as you've heard, was ultimately refused by Blue Cross and AHP was unable to negotiate a group Blue Cross PPO physician contract. Nevertheless, one result of the negotiations was Blue Cross' decision to recognize and support AHP's clinical integration through the funding of AHP incentives for specific

clinical integration programs, including physician participation in Advocate's new EICU program, improvement of electronic claim submission capability in physician offices.

We feel that the establishment of these incentives illustrates the crucial role clinical integration can play in creating administrative efficiencies and improving patient safety. EDI speaks for itself as a streamlining efficiency for both managed care organizations and physicians' offices. Advocate's new EICU program has been likened to an air traffic control for intensive care patients. It provides round-the-clock monitoring of ICU patients from a centralized location by Board-certified, critical care physicians and combines state-of-the-art imaging, telecommunications and video technology with cutting-edge clinical decision support software.

It is absolutely phenomenal to watch this in operation. It has reported to dramatically reduce patient mortality in the ICU by 25 percent, reduces the length of stay by 17 percent and decreases cost. However, Visicu, the vendor of the EICU system has counseled Advocate that the greatest obstacle to implementation of this innovative technology is hesitance on the part of the attending physicians to adapt their accustomed practice patterns to maximize the benefits of the program. As a result of the negotiated incentive from Blue Cross, Advocate Health Partners is now able to provide a catalyst for physicians to become early adopters and advocates of this innovative clinical technology.

Thank you.

(Applause).

MS. OVERTON: Finally, we will have Brad Buxton from Blue Cross Blue Shield of Illinois.

MR. BUXTON: Hi. Good morning, and I guess I'll have to adjust my comments a little bit now, huh, Ernie?

Anyway, my name is Brad Buxton, and I'm here today representing Blue Cross and Blue Shield of Illinois, and we appreciate the invitation from the Federal Trade Commission and the Department of Justice to participate in these hearings on health care and competition. We look forward to sharing our perspectives on PHOs and their impact on the cost and quality of health care today. And I also look forward to a discussion on this issue with my esteemed colleagues.

I want to talk a little bit about my bio as John did, only I think I started sooner than he did, and my first job was in the delivery room at a women's hospital when I was 15 years old. So, no matter what John says, he may be smarter than I am, but I'm much more sensitive.

(Laughter).

MR. BUXTON: I also wanted to let you know that my career includes some time on the provider side also, having worked as a hospital administrator and an association administrator of both the American Hospital Association and the Illinois Hospital Association. So, I'd also like to tell you that I'm a son of a physician who happened to be an obstetrician/gynecologist, and as such, I have some appreciation to

how physicians feel, especially on the matter of quality.

Before I get into my substantive comments, I'd like to provide a brief history of my employer, Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois is a division of the Health Care Service Corporation and we are regulated as a not-for-profit mutual legal reserve company under the Illinois insurance code. We have been part of the fabric of Illinois health care since 1935.

Today, we contract with approximately 22,590 physicians, 223 hospitals, 45 PHOs, 46 IPAs and medical groups. Currently, my role at Blue Cross and Blue Shield is Senior Vice President of Health Care Management, and in that role, I am responsible for a number of things, but one of them being contracting in Illinois with all hospitals, physicians and ancillary providers. It is our group, then, that purchases the physician and hospital services that serve the health care needs of thousands of employers and millions of employees in Illinois.

The work on the provider side, both now and in the past, will serve as the basis for my comments today about PHOs and what we at Blue Cross and Blue Shield believe their impact has been on the health environment in both the urban and rural areas of Illinois. Today I'll try to address what we believe are the purposes of PHOs and why we believe they have proven to be anticompetitive, what our experience has been in contracting with PHOs, and now I'll talk a little bit about the Advocate story, since we've mentioned that today, from our perspective, I repeat, from our perspective.

In our rebuttal to some comments that were made by Lee Sachs of Advocate at a prior hearing, just so we can set the record straight. And, finally, I'll do some concluding brief comments on support of competitive contracting between providers and health plans, highlighting our belief that competitive contracting will help stem the tide of inflationary health care costs.

On the purposes of PHOs, over the years, different constituencies have offered various reasons, as we've heard today, for the formations of PHOs. These include PHOs' improved quality and that PHOs give providers leverage in contracting with payers. Some cynics even suggest that PHOs are there for the purpose of increasing hospital admissions.

As to improved quality, we can report that in our experience there appears to be no difference in the quality of care offered by a PHO than that offered by physicians and hospitals that contract separately. In our experience, no PHO with whom we contract has seen real clinical integration as it relates to PPO and other non-risk arrangements. And I stress that because we have many arrangements with PHOs, IPAs and medical groups where we do have risk arrangements and we do -- there is some clinical integration, but we have never seen it happen on the PPO side. I wanted to stress that.

Blue Cross and Blue Shield of Illinois rates its HMO providers based upon performance in providing patient care in accordance with nationally based clinical practice and preventative care guidelines. And that's based around asthma, diabetes, et

cetera. Of the groups that receive the highest score in promoting outcome-based reimbursement of the quality improvement, there is no difference between PHOs and others. And this is important because we actually reimburse by obtaining those quality levels. Actually, there is an incentive pull that as you reach these quality levels on preventive care, that actually generates payment to your HMO or medical group or an IPA. Moreover, Blue Cross and Blue Shield has been more successful negotiating quality outcome based reimbursement with medical groups rather than PHOs, and to this point hospitals.

Regarding PHOs giving providers greater negotiation leverage, that is a different story. We believe PHOs have been quite successful in wielding power in contract negotiations. As such, these PHOs have contributed to some of the runaway inflation in health care costs, without producing any corresponding quality increase. Additionally, anecdotal information would indicate that hospitals having created these PHOs, have increased their admissions from these physicians from whom they contract.

Our experience in negotiating with PHOs. Although not all PHOs have utilized unfair bargaining tactics, the trend is definitely on the rise. On occasion, we have experienced outrageous demands for increased reimbursement and we have seen abusive use of market power.

One of these tactics includes leveraging of the hospital off the physician and vice versa. This happens quite frequently, and it's not always with PHOs, it's

sometimes just with physician groups who are related or close to hospitals. In antitrust terms, this is known as illegal tying. Another PPO negotiation tactic is negotiating non-risk contracts on behalf of numerous independent physicians. This conduct is, as you've heard today, is known as price fixing. And I'll get into that in a little bit more in a minute.

In one Illinois town, and this was just very recent, a physician group that controls over 50 percent of the market and is part of a hospital clinical arrangement demanded a 375 percent of Medicare reimbursement rate. In another Illinois community, a hospital and physician group each declined to deal with Blue Cross unless we agreed to meet the inflationary demands of another. They both are, we believe, owners in another health plan and the most egregious example of havoc a PHO can raise.

Of course that is really more -- we can show that in a greater example and regarding the contentious negotiations we had with Advocate Health Care, and I'll talk about that now. And I'll refer to it as the case study. And this really comes from the pleadings of the lawsuit, so we're laying it out as it is in the lawsuit, so as John asked, if you go and read it, this is pretty much what you'll see, but this comes from our point of view.

And Blue Cross has had various contracts with each of Advocate's nine hospitals located in Chicago and its suburbs, the hospital contracts, for years. Advocate jointly negotiates the terms of these hospital contracts for all of its hospitals.

The hospital at issue expired on December 31, 2002. And that was for all hospital contracts. That was both HMO, PPO and point-of-service. It was not just for HMO or PPO.

Blue Cross and Blue Shield and Advocate, we felt, had virtually -- had completed the negotiations of the terms of this new hospital contract of which Advocate would have obtained, we believe, a significant rate increase and other beneficial contract terms. In addition, Blue Cross and Blue Shield had PPO agreements with approximately 2,800 physicians affiliated with Advocate's hospital through its PHO. The PPO agreements had been in place between Blue Cross and these independent physicians for many years.

Our contracts basically are evergreened, and we reset the fee schedule every year, and these agreements commence on an effective date some time ago and remain in effect until terminated by either party upon 30 days prior written notice. Typically physicians do not renegotiate the terms of their PPO contract on a yearly basis, and we have very little turnover in our PPO, I believe less than 1 percent.

Because of Advocate's size and the geographic dispersion of its hospitals throughout the Chicago Metropolitan area, these hospital contracts and PPO agreements are important to health care plans offered and administered by Blue Cross. And approximately 20 percent of Blue Cross members receive medical care through our various products through physicians on staffs at the Advocate hospitals.

The PPO agreements between Blue Cross and the independent

physicians provide that Blue Cross will pay a physician for covered services provided to a PPO patient. Payments are made directly to the physicians pursuant to a predetermined discounted fee schedule. This type of fee-for-service contract where physicians are paid certain fee-for-services actually provided does not shift any risk to the physician.

Advocate and its PHO attempted to obtain an agreement from the independent physicians affiliated with Advocate PHO to allow the PHO to collectively renegotiate on the independent physician's behalf, their PPO contracts with Blue Cross. In connection with that negotiation, the PPO sought a significant rate increase. This means devised by Advocate and its PHO to engage in collective negotiation was through a so-called agency agreement with the PHO. This agency agreement purported to give the PHO the authority to terminate an independent physician's individual PPO contract with Blue Cross and to renegotiate a new contract.

In August -- 30, 2002, a letter for approximately 2,800 member physicians in the PHO, Dr. Sachs, President of the PHO, informed the physicians of his proposal to negotiate on their behalf and enclosed the agency agreement for signature. Advocate and Blue Cross, as I mentioned, were near the completion of negotiations concerning the Advocate hospital contracts and HMO medical service agreement for the period beginning in January of 2003.

Advocate and its PHO told Blue Cross they would not sign the hospital contracts and the HMO medical service agreements unless Blue Cross and Blue Shield

agreed to unprecedented increase to the reimbursement rates paid to the physicians under the PPO agreements that were now trying to be jointly negotiated by Advocate.

Further, Advocate publicly announced its intention of terminating the hospital contracts, unless Blue Cross capitulated to its demands and collectively negotiated independent physicians' individual PPO contracts.

On October 1, 2002, Dr. Sachs sent two letters to Blue Cross. One letter was a notice of termination on behalf of Advocate Health and Hospitals Corporation and Advocate Northside Health Center Network for the hospital contracts for the nine Advocate hospitals effective January 1, 2003. The other letter was sent by the PHO, purportedly on behalf of 1,700 physicians, terminating effective January 1, 2003.

The participation agreements between Blue Cross and the Advocate PHO providers were all Blue Cross and Blue Shield health care programs. Included with the letter was an eight-page list of physicians entitled AHP physician listing for Blue Cross PPO termination notice. Despite Blue Cross' request, the PHO refused to provide Blue Cross with copies of the agency agreement purportedly signed by the 1,700 physicians, whose names were included on the AHP listing for termination notice.

Through a phone survey, because we still had contracts with these physicians, we had to call all of them and subsequently learned that a number of physicians for whom the PHO had purported to terminate the independent PPO

contract did not sign the agency agreement or did not understand it.

On October 2nd, 2002, Advocate's PHO, though Dr. Sachs, sent a letter to health insurance plan brokers and insurance agents concerning the status of negotiations between Advocate and Blue Cross, interfering with Blue Cross' relationships with its members during an open enrollment period, the time which over half of the Blue Cross members decide if they wish to continue their Blue Cross coverage. By insisting upon collective negotiation on behalf of independent physicians and refusing to enter into the hospital contracts unless Blue Cross succumbed to the collective negotiation, the PHO attempted to coerce Blue Cross to enter into illegal negotiations or face the prospect of having Blue Cross members move to other health care plans.

The physicians who belonged to the PHO were not financially or clinically integrated with respect to the PPO agreements. Blue Cross repeatedly requested that the PHO provide evidence to support the claims of clinical and financial integration with respect to the PPO agreements. Advocate in its PHO never did provide such evidence, but said that they would work towards it.

Advocate took its fight to the press, taking out full-page newspaper ads, casting Blue Cross as the bad guy. Left with no alternative but to capitulate to strong-arm tactics, Blue Cross filed suit. This suit was later settled and the hospital and HMO contracts were signed. But the physician and PPO agreements were not part of the deal. And I would say that at the end of it, the deal did go through and we

did get some good things, as did Advocate.

Rebuttal to the Lee Sachs testimony, I think this is important because we applaud Advocate for its initiatives regarding quality, as so eloquently described by Dr. Sachs and today Ernie. But as a major health plan interested in quality, we at Blue Cross find it curious that Advocate is categorically opposed to reimbursement based on quality outcome data. They have flatly turned us down two times in negotiation to actually pay reimbursement based on outcomes. And while we did agree to the EICU and some administrative plans, these were more process than actually outcome.

Next we wish to dispel Advocate's claim that the physicians and hospitals with whom we deal are underpaid. Our data shows that both hospitals and physicians have received significant increases in their net paids over the past three years. Net paids really represent the total amount we pay for all services rendered to Blue Cross and Blue Shied patients. You might consider it the Blue Cross and Blue Shield W-2 for a hospital or a physician.

For example, during this period, certain physician specialty groups in Illinois obtained net increases, between 64 and 98 percent. That's during the three-year period of 1999 through 2001. While services for those providers at Blue Cross and Blue Shield only increased between 41 and 61 percent, and patient loads only increased between 31 percent and 44 percent. Likewise on the hospital side, net paids increased from 22 percent to 64 percent, services between 16 percent and 50 percent and patient loads only increased from 13 percent to 35 percent. We'll actually put

these graphs in our published comments that we turn in after this.

At Blue Cross and Blue Shield, we pride ourselves on being a fair but prudent purchaser of health care services. In order to make sure that we remain competitive in our reimbursement structure, we conduct our own studies, plus we participate in independent third-party studies. One such study published to participants in February of this year in this Medicare Payment Advisory Commission regarding characteristics of physician payment methodologies and fee levels used by private health plans.

This study of health plans with combined commercial enrollment of more than 45 million members shows that Blue Cross and Blue Shield of Illinois pays physicians solidly within the middle range of payers. We have other studies that show our hospital payments are also within reasonable market range. Thus, we take issue with providers, such as Advocate, that claim we underpay. We pay fairly but prudently. We do our best to keep the cost of health care within the reach of our employer groups and their employees.

I also wish to comment on the UP, which is called Uniform Payments, reference by Dr. Sachs. They are essentially interest-free loans of two months worth of contractual allowances for the life of the contract. Dr. Sachs suggested that Blue Cross' exemption from the Illinois prompt-pay laws was somehow unfair. However, the truth of the matter is that because Blue Cross pays hospitals in advance of services being rendered, the prompt pay laws simply do not apply. However, if you were to

look at how fast we do pay claims, we pay 98 percent of our claims, actually process them, within 14 days; and physicians are paid on an average of seven days, which is, I believe, much better than anyone in this room can actually say they could do.

Lastly, one final comment to Dr. Sachs who also commented that a 5 percent margin on operations would be great. I will go on the record right now offering Advocate a cost plus 5 contract for as long as they like. The consumers of health care at Advocate would pay far less than they do now if our deal with Advocate were capped at an audited financial cost plus 5 percent, and that would include all costs.

The tale of Blue Cross and Advocate is not presented to stir up antagonism or to air a private matter in public, although it's been aired quite frequently. Rather, it is presented to provide an example of abusive market power and its potential effects upon competition. We believe competition is a good thing. We welcome competition from other health plans and sincerely believe that rigorous competition among health plans and fair negotiations between health plans and providers will result in higher quality at lower costs for consumers.

Although we are not categorically opposed to PHOs, we do believe that the temptation is great, especially for larger ones with market power, to abuse this power to the detriment of competition. We do not hold PHOs solely responsible for the rising costs of health care. We do understand that there are many forces that bear on the incredible rise in health care costs.

We understand that nursing shortage, malpractice crisis, the cost of technology, government funding and drugs all contribute to the problems today. Although some may disagree, we firmly believe that with margins averaging a little over 3 percent, we do not contribute to the rise in health care costs, but rather as a prudent purchaser, we are doing our best to keep health care affordable.

In closing, we again thank you for this opportunity to provide these remarks and to participate in this educational hearing. And we look forward to the discussion.

(Applause).

MS. OVERTON: We'll take about a ten-minute break and then reconvene for our roundtable discussion.

(Whereupon, a brief recess was taken.)

MS. OVERTON: We're going to go ahead and get started again, and we're going to begin with a very short rebuttal to the Blue Cross testimony from Thomas Babbo, who is in-house counsel for Advocate.

MR. BABBO: I don't want to take up these hearings trying to rehash our once very public dispute with Blue Cross, which obviously was amicably settled by both parties. The lawsuits were dropped; both parties have an arrangement. Obviously, though, since those were the -- Brad's statements were taken directly from their complaint at the time, they were assertions that should be taken in that context and obviously we categorically deny the characterization, certainly with regard to

Advocate Health Partners exercising any sort of misuse of market power.

We also want to express our surprise certainly in the assertion that PHOs do not have a capability to impact quality, especially through a clinically integrated model for fee-for-service contracting, since this is certainly an area that is on the frontiers of health care and has not been impacted very extensively by disease state management.

With that, I'd like to no longer distract the hearings with Advocate and Blue Cross' former disputes. We certainly would welcome discussions on any future offers from Blue Cross to consider our clinically integrated model and proposals and will take into consideration any offers from Blue Cross with regard to hospital contracts in the future.

MR. BYE: Thanks very much. I wanted to ask a question about the relevance of PHOs. PHOs developed in response to managed care largely, and that is on the decline to some extent. How are PHOs relevant today?

DR. WEIS: Maybe I can take a shot at that. Based on my experience over the last 20 years in various kinds of managed care and on both sides of the issue, both in terms of payers and providers, I don't see any long-term possibility of improving the quality of health care or lowering cost if physicians continue to practice in a fragmented manner with small practices, with no clinical or financial integration. The vast majority of physicians in Chicago were similar to the practice that I was in for 20 years. There were four pediatricians in a group and that practice is still there.

You're unlikely to get the use of protocols to reduce variation and improve quality under that system, which is supported by unregulated fee-for-service reimbursement. Some form of clinical and financial integration is necessary in order to achieve quality improvement, cost reduction, and better patient safety.

There are several entities in our country that could provide the focus around which clinical and financial integration can occur. Physicians can do it on their own. They certainly have done it successfully in some areas. You can count the number of successful large group practices in Chicago on one hand. So, I think there's very little likelihood that that movement will spread. Physicians by nature do not cooperate easily with their own colleagues, and certainly not in large groups. So, that model, I think, does not stand much opportunity for success.

The other entities in our society around which clinical and financial integration can occur are the payers. And I spend a considerable amount of time attempting to achieve that as Vice President of Managed Care and Medical Director for several large payers in the Chicago area. I think it's very unlikely that they're going to be successful. They've tried it; there are very few models in the Chicago area or elsewhere in the country where clinical and financial integration around the payers' side has been successful.

It can be done with using the equity model, that if ICOR and Med Partners certainly tried to do that and have failed. Really, it seems to me, the only logical entity in our society around which that kind of integration can occur are

hospital systems. And certainly it hasn't been done successfully everywhere, but there are successful models, including Advocate. Physicians require the management skills, the capital accumulation, systems integration of some organizing entity, and my feeling is that the hospitals are the most likely entity in our society around which that can occur and should be encouraged.

MS. OVERTON: Meg has indicated she wants to respond.

MS. GUERIN-CALVERT: I just would like to add one thing. Matthew, in the introduction to your question, you indicated that there's a decline in HMO, and while it is the case that there's been an increase in the proportion of enrollees that are in PPO kinds of products, nonetheless an HMO product remains a very, very substantial part of the delivery of health care.

And I think as some of our panelists, particularly Ernie, had mentioned, in terms of walking through the diagram, fairly fully integrated systems, including PHOs, have been able, some of them still, to successfully deliver full-risk capitated arrangements. So, not everyone has been able to do that, a number of hospital systems have exited from that, but a number of the very large systems have been able successfully to manage costs, to deliver a fully integrated health care plan.

And, so, I would expect that in that particular context PHOs would continue to remain very relevant. Again, it's an alternative mechanism, other than having the managed care plan provide the HMO product and take on that level of risk, in which a different contracting mechanism can develop. Again, that may be declining

some, there may be some challenges, but I think as long as that remains a viable product PHOs would be relevant for that reason as well.

MS. OVERTON: I want to follow up on this point regarding clinical integration and Dr. Weis suggesting that PHOs are particularly well equipped to achieve clinical and financial integration. Dr. Weis, how are PHOs able to overcome some of the challenges inherent in relationships between physicians and hospitals such as loyalty and trust challenges?

DR. WEIS: Wow. Not an easy question to answer. Certainly we haven't solved all the problems. If you'd attend any of our individual PHO board meetings or the super-board, they're contentious, and there's still a great deal of suspicion on the side of the physicians that we don't always have their best interest at heart. Sometimes physicians tend to, you know, set themselves against each other and against the hospital.

We have to be able to deliver a product, a system, that benefits as many of the constituencies as possible, and it's quite true that sometimes we take decisions that one particular specialty or small group of physicians in one geographic area may see as not in their own best interest. But overall, I think we're able to bring more value to our participating physicians and the hospitals than they would be able to achieve individually.

Don't forget, in addition to the 600 physicians that belong to our employed groups, which do form the core of our PHOs, there are 2,600 other

physicians, independent physicians, that participate voluntarily, so they see value in participating in our full range of products. And if they're a member of our PHOs, they must participate in the capitated products. They don't all like it because their reimbursement rates are lower than they experience in the fee-for-service world, but it gives them access to our PPO contracts, as well, and their participation in our clinical integration activities is a key to that participation.

It's only because we continue to bring value to our participating physicians that we're able to continue and to thrive. And I think we can extend the value of that even more if we could convince the payers to more actively participate in our clinical integration through fee-for-service products, as well.

MS. OVERTON: Okay, I'd like to ask the panelists, given what we've heard in Jeff's presentation in particular about skepticism among antitrust enforcement authorities about clinical integration, is there a way that PHOs can achieve clinical integration, not run afoul of the antitrust laws and not put too much burden on the PHO infrastructure.

MR. MARREN: I'd like to answer that. I think if you look at what AHP does, and they're one of many -- not many, but some -- who do this, they take the data that they received on a capitated patient basis, they pick out various diseases and they look at those and they begin to manage variation. They eliminate or reduce variation in the way that patients are treated. The folks who are experts at this stuff, the doctors that I talked to talk about the ability to greatly reduce costs, greatly reduce

hospitalization, eliminate perhaps medical or pharmaceutical contradictions and things like that.

So, the issue is really, is a PHO viable, the issue is do they have the data, can they participate, do they have the manpower, do they have the organizational structure. I'd be skeptical of a PHO that had no organizational structure, no medical management, and no data who said that they were doing clinical integration. On the other hand, I think Ernie's right. I think the real issue here is trying to get the payers to responsibly participate in clinically integrated programs so that the data is there on a fee-for-service patient basis.

The patients -- the PPO patients that the Advocate doctors see right now do not have the advantage of access to that kind of quality management that the HMO patients do, and that's ridiculous, because most of the patients that we have in our market are PPO-type patients. The managed care plans have not engaged in true medical management or quality management, and that's not their business, it really should be a grass roots effort by physicians, using data from plans.

That way -- therefore, what we should be focusing on is the kind of relationship between a payer and providers that allows for that kind of data and joint negotiation, collectively integrating physicians in a real manner. I'm not talking about some sham deal to try and impact price or coerce anybody to do anything. I'm really talking about the ability to dramatically impact quality.

If you look at what the Institutes of Medicine have produced in terms

of data on quality in this country, we should stop everything right now and focus on these systems and make quality a lot better on the PPO side. So I'd be skeptical of someone who didn't have the organization, the will or the experience who said they were going to do it. But I wouldn't be skeptical of somebody who had the ability and the commitment and the willingness to follow through.

MR. BYE: I just want to focus at a more practical level, when looking at PHOs and you have various parties making claims, how do or how should the agencies distinguish between them? What evidence should we look at to support claims?

MS. GUERIN-CALVERT: I think one thing would be building on what John said, would be looking at the mechanisms that are being employed by the particular PHO, so focusing first on the business justification, separate and distinct from market power considerations. And whatever is, I think, what it takes is looking particularly at the mechanism that's going to be set up, the contractual arrangements, in relation to the expected outcomes, be it cost savings, be it other forms of efficiency, or being it systems or outcomes to improve quality, in the same way that we've all, I think, gotten fairly comfortable with the use of financial mechanisms and as a result the incentive structure that are set up.

I think we need to explore more the issue as to what are the mechanisms other than financial arrangements that lead to improvement in outcomes. I was really intrigued listening to Ernie's presentation. I had not heard it presented

before. The idea that different kinds of marketplace arrangements that we have seen in the form of large physician management organizations, in terms of developments by payers, all of which are extraordinarily well intentioned, may not have achieved certain kinds of outcomes, and that PHOs may be better able to accomplish certain kinds of things. I think that would be something to be looking at.

I think in terms of market power concerns, again, I think it's very important to be very practical. My experience has been it is extraordinarily rare where you have a significant intermediate market situation, as Serdar had mentioned, where you have a set of hospitals and a set of physicians that have very, very large market share. It's usually the case where there are a lot of alternatives and the ability to shift on the margin. And then lastly I think it's important to think about whether there is a kind of countervailing bargaining on the part of the managed care plan -- is it so important to the hospital systems that there is a balance? So, I think it's -- the market structure is an important part to distinguish among cases, but I think we should all spend a lot more time looking at the business justifications.

MR. MILES: I think related to that, if you want a perfectly practical, succinct answer, the answer is look at the documents. I have yet to see a PHO or another type of provider contracting network set up for the wrong reasons from an antitrust standpoint where that was not well documented in the organization's documents. From a counseling standpoint, quite honestly, you just cannot keep those documents out.

MR. BYE: Serdar?

MR. DALKIR: Yes, thanks. Just briefly, I just want to put forth two different types of efficiencies in looking at PHOs. The first type of efficiencies are between the doctors, and you can expect those type of efficiencies arise whenever a bunch of doctors come together and organize among themselves, without necessarily the participation of a hospital. The second type of efficiency may come in when the doctors who have already organized among themselves, and I'm putting this in a stylized context, when the doctors come together with the hospitals, there may arise additional efficiencies from that integration. So, my advice to the agencies would be, first of all, to try to disentangle one type of efficiency from the other.

And the second point I'd like to make is I think exclusivity would be key to some of the anticompetitive effects or potential anticompetitive effects. And the agencies may ask whether a certain hospital who has entered into an exclusive relationship with a group of doctors has also sought exclusivity in other areas or services with the intent to minimize substitution to other hospitals.

MR. BYE: Thanks.

MR. DALKIR: Thanks.

MR. BYE: Meg, you mentioned market power among hospitals and physicians. I wonder if you or anyone else would comment on the circumstances that we're likely to see such market power.

MS. GUERIN-CALVERT: I guess my sense is that's a little bit easier

to describe the principles than to identify whether or not there is likely to be a market power concern, because I think -- my overall reaction is that looking at market share alone in terms of the proportion of the physicians, even by a particular specialty, that belong to the PHO and the relevant size of the hospital, both generally and also in terms of its share of commercially insured patients in and of itself tends to give you relatively little information that's useful for identifying whether you have market power.

So, I think, you know, my sense is that it's particularly important in terms of looking at the extent to which there are physicians outside of the PHO, whether or not additional physicians can be attracted into the particular community and also looking beyond the idea of whether or not the only mechanism available to the plan is to either include or exclude the hospital. I guess in my experience most of the way in which negotiations actually work is much more sophisticated than in or out of the network.

It's a lot of ability to move on the margin, and it's some of the points that Serdar mentioned in terms of the ability not only to divert patients from the given hospital, but for the plan to make much more use of the other physicians and the other hospitals that are in the area over the near term to longer term. So, there I think it's looking at not just where else the physicians that are in the PHO may have admitting privileges, but the ability of other hospitals to reposition themselves and to look at other physicians.

To the extent those conditions don't exist, where the ultimate arrangement has a very, very large share of both, again, then I think you end up having to look at whether or not it's just essentially almost a bilateral monopoly situation.

MR. MARREN: Market power is an interesting concept. If I'm a plan and there's a very attractive set of hospitals and doctors that I want because my enrollees want them in the plan, does that mean they have market power from an enforcement perspective? I think as the enforcement agencies look at this issue, you have to be very careful to not say just because I'm very attractive from a market perspective means I have market power. In Chicago Land, no one has market power. There may be some isolated pockets where somebody does, but in general, there are so many hospitals and doctors that it's incredible.

So, I think as the law evolves in this area and we define what market power means, I would encourage an approach that doesn't just look at attractability or attractiveness in the marketplace and make that a metaphor for market power.

MR. MILES: Is that sort of a distinction between market power and economic rents?

MS. GUERIN-CALVERT: It could certainly be. In other words, if you get a premium because you're higher quality, exactly right.

MS. OVERTON: Does anyone else have a different take or an additional take on the point that John was raising about an attractive hospital or an attractive group of physicians or, as some might call it, a must-have hospital?

MR. BUXTON: Maybe not a different take, but I think there are different ways to look at how a hospital or physician group actually draws patients, where they draw them from, why they draw them from there and whether or not that hospital, if it was combined with another, would actually create a problem with market power. What we tend to find is that people will go to a hospital because they go to that hospital. They won't cross a river; they won't cross a highway; they won't -- you know, those types of things.

And it's very hard, because they're not hard variables to study, but I know there are some markets where a hospital on the north side of town combined with a hospital in the center of town and everybody said oh, there's plenty of distance between them, people -- you know, it won't be a big issue. And yet nobody ever crossed the river. People would not cross the river to go to the other hospital and there was clearly a decline in competition in that area. I don't want to mention which one it was. So, I think that there are certain things that you have to look at.

Hospitals do patient origin studies and they do them for a reason. Now, we look at patient origin studies because we want to know where people actually go. You know, there are hospitals, as John said, that are popular because they're popular. You know, they were in U.S. News & World and they answered the questionnaire right and they're the most top-notch, quality hospital in the country. It had nothing to do with outcome, but they're good.

So, you know, you really have to look at a number of different

variables, because nobody knows what the true variable that draws somebody to the hospital. It could be I was born there, it could be my dad was a doctor, it could be -- but in the ultimate analysis, there's a reason that people go to certain hospitals and certain doctors, and they tend not to change from that. And, so, if we could figure out what that is, you could actually probably define the market and when market power is actually gotten.

MS. GUERIN-CALVERT: That I think is one of the best explanations I've heard of the value of patient origin data and how the multiple participants in the industry use it. And the only thing I would add is just from an economist's perspective, having looked at a lot of patient original data, it is the case, there's always some significant proportion of the patients flowing to any given hospital that are exactly characterized for all of the variety of reasons that you mentioned who are unlikely to switch from that given hospital or maybe would only consider one other hospital as an alternative.

But in the vast majority of cases that I've seen, you usually have somewhere between 20, 30, 40 percent of the patients who are much more flexible in their choices and who managed care plans have worked very hard with to move them into the lowest cost hospitals. The hospitals themselves are most worried about how do they keep those people coming in from longer distances. They're the ones that they're most worried to lose. And I think that ultimately then does determine whether or not a given merger or a given hospital has market power, is are there enough people

on the margin who can and will move, even if 60 percent or maybe 70 percent or a larger percent are unlikely to move. And that I think is the determining factor in a lot of cases.

MS. OVERTON: We've heard during this session and some past sessions that a number of PHOs have failed, that a number of surviving PHOs are small or non-exclusive or don't have market power. What structures are arriving or have arisen that are attempting to achieve some of the anticompetitive effects that PHOs -- certain PHOs -- were allegedly created to achieve, such as raising rivals' costs or improperly achieving leverage in negotiations?

MR. MILES: Nothing that I know of.

(Laughter).

MR. MARREN: My comment would be that the very -- I think it was the second -- it was 1983 or something like that, but it was the second PHO I ever worked on, got done with the formation, we had all the documents in place, we started talking about contracts and contracting, those doctors looked at me and said are you nuts, we're not contracting with these managed care plans, but they never went very far.

But that was a long time ago. The people that are still around are either functioning quasi-effectively from a financial perspective or badly from a financial perspective. And it's a hand-to-mouth kind of thing. One of the things that I do empathize with Brad about is the concept that if you're in Illinois it's going to cost

you a lot of money if you're funding IPAs or PHOs that go belly up, because you have to keep paying and paying and paying.

And it's very difficult for them to extricate from the Blues or other plans to extricate themselves from a financial nightmare that occurs at an IPA or a PHO. But the ones that I've seen, again, more recently, and there is a different medical culture out there with respect to managed care. I know there are people that -- doctors -- if you go up to any doctor and ask him if he liked managed care, the answer's probably going to be no. But in reality, there are a lot of people really working hard at, quote, managing care and trying to live within the budget, and I think those are the legitimate ones. I think if people are doing something different, it makes almost no sense. There's really no financial advantage to trying to, you know, sort of manipulate the game plan, I guess, at least from my perspective.

MR. BUXTON: Just related, I feel funny doing that. Nobody's bursting in. Clearly there are IPAs and medical groups out there of different and varying integration levels. And we have gone through the trials and tribulations of financial bankruptcies and those types of things where we end up having to pay twice and I think that what we finally learned, and whether this is an indication of what has to happen with PHOs or not, is that a lot of payers in the past when it came to IPAs and medical groups, not necessarily PHOs, but maybe PHOs who operated, is when they delegated the risk, they basically delegated caring. And, so, they would say, well, here, take it and have a nice day, I've given you the risk and I hope you can make it.

What we learned a while ago was that once we delegated we had a larger role to play and to make sure that these entities could be successful and that, you know, you don't just put the risk on them and then when they go out of business go back to fee-for-service, because capitation is a very, very good model. It retains the patient-physician relationship and there are a lot of good things that can happen with it. But it then becomes incumbent upon the payer to do things that will ensure that those places can stay financially viable. And that is something that really hasn't been thought about by payers as much as payers need to think about it.

But on the other hand, there need to be financial controls in the IPAs and medical groups and people can't be buying boats and cars and houses before they pay their bills and so on and so forth. So, I think there has to be more -- I don't know whether that it would be rationality or more vigor in the process and that payers need to do what payers do well. And you know, why do we have separate IPAs and medical groups even paying claims? I mean, that's what payers do, that's what they do well.

And, so, when you're looking at these things, and I think, you know, somebody said it well, look at the documents, look at who does what, because you have to look for the financial viability out in the future, too. You can't just look at it as, you know, never mind the legal aspects, look at the financial viability aspects, because I do think that IPAs, medical groups, freestanding, negotiating separately if part of a PHO, can be very viable entities.

DR. WEIS: You know, I think that Blue Cross is a good example of a payer that has taken responsibility, certainly recently, in being more involved in the operations of the IPAs that they contract with. But what it speaks to is the sophistication and the financial viability of the organizations around which the IPAs and the PHOs operate. Many of the IPAs in the Chicago area are purely physician-run. They have, you know, relatively rudimentary systems, and it's inevitable that those are going to go bankrupt.

What I'd like to see is the payers taking a more active role and encouraging the development of hospital-based IPAs and PHOs, where there would be the level of sophistication and financial stability that's required to accept risk. So, I think that's an important issue.

The second thing that I wanted to point out is that while there are a great number of physicians that participate in Advocate Health Partners who are independent practitioners on the staffs of our hospitals, about half of the physicians on the staffs of our hospitals do not participate in managed care or in our PHOs. And the reason is that they can attract enough business at higher reimbursement rates and therefore have no interest in participating in managed care.

And as the emphasis on managed care has declined in recent years, there's less interest among the employers and among the patients and in the payers in managed care, the drift away is likely to increase. So, there's plenty of opportunity for physicians not to participate. There's no coercion involved. The physicians who

participate obviously continue to want access to managed care HMO patients, as well as the PPO patients.

MR. BYE: There are a lot of theoretical justifications for PHOs. I think it was Professor Burns who surveyed a number of physicians about their motivations for joining PHOs and found quite a disconnect between the theoretical literature and their motivations. Should that influence the way that we think about PHOs?

DR. WEIS: Well, I'm not exactly sure, to be honest with you what question you're asking. I think I answered that. It seems to me that physicians participate. Independently practicing physicians participate in managed care because they see an economic reason to do so, and if they don't, they don't participate. In other words, if they have enough business coming their way at higher reimbursement rates, they don't participate.

MR. MILES: I think the answer is, I mean, obvious, yes. If the question is should we look at the reason individual physicians decide to participate, yeah, yeah. I mean, I think that's very important. It goes back really to the same reason you look at the organization documents. You can participate for a good reason; you can participate for a bad reason. If you participate for a bad reason, that by itself isn't unlawful, but at least it gives you some idea what the effect of the organization might be. I think it's -- I think it's very important.

MS. GUERIN-CALVERT: I was just going to say also there's, I think,

a difference between a broad-based survey such as what he did looking overall at the complexity of reasons for why people join PHOs as opposed to whether or not any individual PHO along the lines of Jeff mentioned is actually set up in an effort to try to accomplish certain gains and to offer those gains, both to the patients and to the physicians, and also whether or not it has succeeded.

I think in antitrust terms, you know, unless there is some sort of circumstance that it was set up as a sham, whether or not it actually accomplishes significant benefits is not our usual standard. Some fail; some succeed, you know, very, very well.

And I think the other part is that having looked at some of those surveys, it does show, I think, the point that Dr. Weis was making, which is that you have physicians with a lot of different motivations, a lot of different issues, operating in a lot of different kinds of structures. And what PHOs, as well as other kinds of arrangements do, is offer some sort of over-arching institution instead of contracting mechanisms to try to align the disparate incentives of a variety of physicians in a way to accomplish something that perhaps in the marketplace they may not arrive at independently. And that could also be why you see a disconnect between the two.

MS. OVERTON: I want to go back to the disconnect -- maybe disconnect is too strong -- but the difference that we heard between the presentation by Brad and the presentation by Ernie about what is attractive to payers, or at least to Blue Cross in contracting with a PHO. And I'd just like to get the views of the

panelists on what are PHOs doing to make themselves attractive to payers, particularly given the decline of managed care. And, so, what is it that PHOs are offering with respect to PPOs or point-of-service plans, because it didn't sound like Blue Cross was finding it as helpful to work with Advocate in the PPO space?

MR. MILES: Can I try?

MR. BUXTON: Uncle.

MR. MILES: No, you go right ahead.

MR. BUXTON: No, no, I was saying uncle. I was kidding.

MR. MILES: Well, I guess I would start by saying my experience is there is a phobia on behalf of all managed care plans of dealing with any type of network, because there is almost an implicit assumption that they are getting together for one reason, and that is to jack up reimbursement, and there is nothing of a beneficial nature that can possibly come out of them. And my own experience is it's another fact-specific question. In some cases, indeed that is true; but in other cases, it's not.

I can give you an example of a clinically integrated network that I worked with that put together, I think, a very good clinical integration program. And the honest truth is they did it for the right reason. But unfortunately, they didn't have much of a business plan before they made this investment, and when the program was up and running, they had a great deal of trouble getting payers to even talk to them about it. The impression they got was that really the payers had no interest in quality

itself, that the payers were interested only in price. So, again, it's both difficult and dangerous to generalize on the subject, but there is, there is a phobia justified only sometimes on behalf of payers of even talking to network -- provider network type arrangements.

MR. BUXTON: Just a -- not direct response, but number one, I would say that we at Blue Cross and Blue Shield of Illinois have exhibited our thirst for seeking quality. In our HMO today, which Advocate is a part of and Ernie mentioned where we work with PHOs, IPAs and medical groups, 83 in all, to be exact, part of our reimbursement methodology and their capitation agreement is a quality fund. That quality fund basically is growing all the time. We put different things in it every year. We put a new study in every year.

Last year we put in influenza shots for chronically challenged and over, you know, over a certain age, et cetera. And every time that that health plan and our HMO gave a person the influenza shot when they were supposed to, $1,000 went into their pool. And we didn't make it -- we didn't do it lightly. It's not like, you know, well, we'll pay you $3 or $4. We started out with $500 when we started the thing, I believe with mammograms and pap smears. And we moved up to $1,000 to make the physicians understand that it was much more important. The biggest problem we've had, quite frankly, is getting the physicians who deliver the care to know that that's what they're being paid for. And we're working on that, and some plans, some IPAs and medical groups do it well, and some don't.

We're beginning to also start a hospital quality profile program, which I mentioned before. And basically the profile takes eight separate procedures in terms of outcomes, things like wound infection after surgery. And what we want to do is, besides some structural indicators, we look at leapfrog indicators, because our major payers are insisting -- our major customers are insisting.

And what we do is we like to sit down with a hospital and say, okay, we've tracked your wound infection rate, let's say over the last two years, we'd like to give you a base increase of whatever percent, and then we'd like to tie the rest of the increase to you improving that wound infection rate and, you know, maybe pulmonary embolism rate after major surgery, if those happen to be two areas. And what we're finding is that we're getting some push-back on that, even though we're comparing that hospital to itself. And this is for all products.

And then the next step will be we'll be looking at how we can move the similar types of programs into the PPO by creating different tiered levels to reimburse higher levels to those who attain higher quality outcomes. So, we are working on it, as I know other payers are. It's not the easiest thing in the world to do, but we are doing it and I think that's the wave of the future.

I do believe and I believe that we've talked to Advocate about it and I think they believe it, too, that in the future, you're going to have to pay by outcome. It's the only realistic thing is part of the production function for hospitals and physicians. It's what they create, their goods and services, their input of goods and

services, it's what they produce, and we're not paying them on what they produce today. We're just paying them based on history and unit prices that came from the past, and that really has to change.

MS. OVERTON: A couple of our panelists need to leave, and so we're going to start wrapping up, and I just wanted to give them the chance to make any final remarks, if they choose to do so.

DR. WEIS: Well, one final remark. I agree with just about everything Brad had to say. I would only add that what we're trying to do, through our PHOs, is extend those same programs to the fee-for-service patient population.

MR. BUXTON: You're negotiating, Ernie.

MS. OVERTON: Thank you. And let me extend that same courtesy to the remainder of the panelists, beginning with Jeff. Any final remarks?

MR. MILES: I'd have to think about it and we don't have that much time.

MS. OVERTON: Meg?

MS. GUERIN-CALVERT: I just want to -- I thoroughly enjoyed this. I think, you know, having this dialogue on what the developments are in terms of quality investments has been very, very productive.

MS. OVERTON: Serdar?

MR. DALKIR: No, I'm just honored to be a part of this panel. Thanks.

MR. BUXTON: Thank you very much. I think I've said more than I could possibly say already.

MS. OVERTON: Well, I'd like to thank our panelists for being here and make a couple of housekeeping announcements. I'd like to remind everyone that you are still able to submit materials for the record, and also that our next hearings will recommence on May 27th in the afternoon, when we'll begin our consumer information sessions. Thank you all again, and thank you, panelists.

(Applause).

(Whereupon, the hearing was concluded.)

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

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: MAY 22, 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 20, 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