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"The Federal Trade Commission's Health Care
Antitrust Program: Chapter II"

Prepared Remarks of

The Honorable Deborah K. Owen
Commissioner
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Before the

American Bar Association Section of Antitrust Law
Forum on Health Law

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The views expressed are those of the Commissioner, and do not necessarily reflect those of the Federal Trade Commission or the other Commissioners.

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Good afternoon. I appreciate the opportunity to join you here today to discuss some alternatives for future directions in the Commission's health care antitrust enforcement program. Let me begin with our traditional caveat that my remarks reflect my own views on these matters, and are not necessarily those of any other Commissioner or of the Commission as a whole.

Like any new member of a judicial or regulatory authority in our legal system, in this domain, I have inherited a rich, albeit contemporary, body of law and precedent; or to paraphrase Billy Joel, I "didn't start the fire." It has now been approximately fifteen years since the Commission became actively involved in the area of health care competition. During those years, the antitrust bar has witnessed a number of major Commission actions that have transformed the dynamics of health care markets.

The application of the antitrust laws to health care professionals and to hospitals has been staunchly and emphatically established. Similarly, recognition that our traditional antitrust analysis is sufficiently flexible to adjust to the particular characteristics of health care markets is firmly ensconced. Blanket prohibitions or unjustified restraints on truthful advertising and the solicitation of patients -- whether imposed by professional associations or by state regulatory boards that are not acting pursuant to their mandate

-- appear to have been largely eliminated.¹ Various coercive boycotts by providers have been struck down. These include boycotts designed to deflect new entry by health care professionals or health care facilities;² to impede cost containment efforts by payers;³ and to obtain higher levels of insurance reimbursement.⁴ Agreements among providers not to enter into employment or other contractual relationships,⁵ or not to practice in "commercial" settings, have also been banned.⁶ The Commission has prohibited efforts by competing providers to negotiate fees on a collective basis.⁷ It has also eliminated a variety of restrictions that impeded the development of health

¹ See, e.g., American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided court, 455 U.S. 676 (1982); Massachusetts Bd. of Registration in Optometry, 110 F.T.C. 549 (1988) (Commissioner Strenio concurring).

² See, e.g., Sherman A. Hope, 98 F.T.C. 58 (1981) (consent order); Medical Staff of John C. Lincoln Hospital and Health Center, 106 F.T.C. 291 (1985) (consent order).

³ See, e.g., Indiana Fed'n of Dentists, 101 F.T.C. 57 (1983), rev'd, 745 F.2d 1124 (7th Cir. 1984), rev'd, 476 U.S. 447 (1986).

⁴ See, e.g., Michigan State Medical Soc'y, 101 F.T.C. 191 (1983) (Commissioner Bailey concurring).

⁵ See, e.g., American Soc'y of Anesthesiologists, 93 F.T.C. 101 (1979) (consent order).

⁶ See, e.g., Oklahoma Optometric Ass'n, 106 F.T.C. 556 (1985) (consent order).

⁷ See, e.g., Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order) (Chairman Oliver concurring).

maintenance organizations,⁸ and a staff report may have contributed to the abolition of physician control of Blue Shield plans.⁹

The initiatives that I have listed were largely complete by the time that I came to the Commission one year ago. For the most part, health care services providers have received the message that the antitrust laws apply to them. By and large, one no longer sees groups of professionals engaging openly in clear-cut restraints on competition. Accordingly, we now see few investigations involving conduct that is patently anticompetitive. Instead, most of our investigations involve activity that necessitates a much more probing analysis of competitive impact. Those who seek to suppress competition in order to raise prices have become more sophisticated, and do not usually oblige the antitrust enforcers with overt declarations of intent to restrain competition, or with openly restrictive conduct. As a result, identifying anticompetitive conduct has become more complicated.

At the same time, we continue to witness dramatic changes in the health care services marketplace. Cost considerations and

⁸ See, e.g., Forbes Health Sys. Medical Staff, 94 F.T.C. 1042 (1979) (consent order).

⁹ See Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule (1979).

the demands of payers play an increasingly large role in purchasing decisions; and providers continue to devise new arrangements for the delivery of services in response to these demands. Many of these arrangements are legitimate responses to market demands; they enhance efficiency and consumer welfare, and should not be discouraged by an unduly burdensome or vague enforcement policy. However, some of these arrangements may be nothing more than concerted efforts to resist market change, though they may masquerade as "legitimate" responses. Others may be generated by a good-faith effort to respond to the market, but may ultimately prove to restrain competition incidentally, more than they enhance it. Certainly, law enforcement authorities must proceed carefully in evaluating these new developments in order to avoid frustrating the emergence of new, more efficient arrangements for delivering health care services.

All of these developments lead me to conclude that Chapter I of the Commission's efforts in this area -- the clear-cut cases -- has come to a close. Chapter II -- the period of exploration in these new murky areas -- has just begun, and may take us in some new directions, necessitating even more sophisticated analysis, investigative techniques, and remedies. At this point, of course, I cannot predict what cases the staff will develop, or how the Commission will deal with these questions, or how I will ultimately cast my own votes. But I think that I can peer far enough into the crystal ball to identify three general areas

where I believe we will likely be called upon to address competitive issues -- information restraints, conspiracies to boycott or to fix prices, and joint ventures among hospitals.

INFORMATION RESTRAINTS

As you are no doubt aware, based on solid economic evidence, the Commission has brought a large number of cases challenging a variety of restraints on information dissemination imposed both by private associations and by state regulatory boards. Among other things, we have challenged flat bans on advertising¹⁰; bans on comparative advertising or advertising of fees or discounts¹¹; and broad prohibitions on certain methods of advertising, such as the use of testimonials.¹² At the same time, the Supreme Court has struck down, based on First Amendment grounds, some state laws that categorically restrict certain kinds of advertising.¹³ This two-pronged assault suggests that any remaining, categorical bans on professional advertising are vulnerable and bear a heavy burden of justification. The exception, of course, is any ban on

¹⁰ American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided court, 455 U.S. 676 (1982).

¹¹ Oklahoma Optometric Ass'n, 106 F.T.C. 556 (1985) (consent order).

¹² Massachusetts Bd. of Registration in Optometry, 110 F.T.C. 549 (1988) (Commissioner Strenio concurring).

¹³ See, e.g., Peel v. Attorney Disciplinary Comm'n of Ill., 110 S.Ct. 2281; 58 U.S.L.W. 4684 (June 4, 1990) (No. 88-1775); (notation of specialty certification on attorney's letterhead may not be totally barred); In re R.M.J., 455 U.S. 191 (1982).

deceptive advertising. These bans are, by definition, procompetitive and further the interests of consumers.

Some examples of conduct that may be subject to regulation are highlighted in a series of recent consent agreements that the Commission has accepted for public comment, involving infertility clinics. Although these cases emanated from our Bureau of Consumer Protection, they illustrate the complementary functions of the Commission in the antitrust and consumer protection areas.

Specifically, the Commission's complaint accompanying the proposed consent orders alleges that the respondents misrepresented the success rate of the infertility services that they provided. The source of potential confusion and deception of consumers was the apparent debate within the medical community concerning what constitutes "success" and, therefore, what factors should be used to measure it. As to the denominator in the equation, should it include all patients who complete at least one treatment cycle; or, should it include only those who have completed a certain recommended number of cycles? Then, as to the numerator, should it represent the number of chemical or clinical pregnancies, or should it be limited to live births? Without taking a position on the merits of the best definition of "success rate", the orders recently accepted by the Commission

for public comment in these cases¹⁴ require, inter alia: that the measure of success be disclosed; that the success rate not be misrepresented; and that there be a reasonable basis for comparisons with other methods or providers.

Obviously, we must carefully balance the harmful effects of restraints on the dissemination of truthful information, against the need to protect consumers from deceptive or misleading advertising. In striking that balance, we must also keep legitimate First Amendment concerns in mind. One area that is of particular interest to the medical profession is advertising relating to specialization or certification. The Commission's staff has opposed in a number of advocacy comments, first, flat prohibitions on advertising certifications or specializations, and, second, limiting permissible certification advertising to state-operated certification systems.¹⁵ The staff's position in these comments is that truthful advertising claims concerning

¹⁴ IVF Australia, No. 892-3225, and NME Hospitals, Inc., No. 892-3144.

¹⁵ See, e.g., Comments of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission on the May 1987 Exposure Draft of the Model Code of Professional Conduct of the National Association of State Boards of Accountancy (June 12, 1987); Comments of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission on the advertising regulations proposed by the New Jersey State Board of Dentistry (July 14, 1987); and Comments of the New York Regional Office and the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission on the Rules of Professional Conduct governing advertising by lawyers in New Jersey (November 9, 1987) (Commissioners Bailey and Azcuenaga dissenting from authorizing staff comments).

certification or specialization may convey valuable information to consumers, and that regulation should employ narrower means to prevent deception.

The Commission itself filed an amicus curiae brief in the Supreme Court in the case of Peel v. Attorney Disciplinary Commission of Illinois, arguing that a ban on all truthful representations of professional specialization or certification violated the First Amendment. As the brief pointed out, voluntary certification programs can help redress the imbalance of information about the quality of services that commonly exists in professional service markets, and can help consumers distinguish among practitioners based on their experience, knowledge, and skill.¹⁶ The Supreme Court held in that case that flat bans on the advertising of certification granted by legitimate certifying bodies do not pass muster under the First Amendment.

As the Commission's Peel brief also pointed out, consumers are best served by certification programs when the certification represents an objective measure of a professional's performance that is relevant to the services the professional provides. These conditions are not met, for example, by a "certification mill" that supplies certificates without an objective evaluation

¹⁶ Brief for the Federal Trade Comm'n as Amicus Curiae, Peel v. Attorney Disciplinary Comm'n of Illinois, 58 U.S.L.W. 4684 (U.S. June 4, 1990) (No. 88-1775); 100 S.Ct. 2281 (1990).

of the candidate's qualifications and performance, or that conducts an inadequate evaluation. In these cases, claims about certification may be misleading.

Consumers may be unfamiliar with professional certification bodies, and therefore may be uncertain about how to evaluate certification claims that pose the potential for abuse. For these reasons, certain kinds of public or private regulation of certification claims may benefit consumers. Generally, however, consumers are best served by regulation tailored to prevent deception, without unnecessarily impeding the publication of useful information.

While I myself am not yet in a position to advocate or endorse any particular approach at this time, there have been discussed a number of ways that private associations or public licensure boards might regulate certification claims. One approach is to "certify the certifiers" -- either through voluntary accreditation of certification bodies by private organizations, or through a requirement of government approval of certification bodies.

Another suggestion that has been advanced is to require that certification claims be accompanied by disclosures explaining the consequence of certification that might not otherwise be understood by consumers. While, as many of you are aware, the

Commission has often required disclosures in consumer protection orders to prevent further deception, our experience there cautions us that such requirements must be imposed judiciously, because, otherwise, they can discourage truthful claims.

Public and private regulations are not the only mechanisms for increasing consumer awareness about certifications, and avoiding misunderstanding. Through advertising, certifying bodies can also attempt to differentiate their own imprimaturs from those of other organizations. Such advertising may be designed to educate -- to familiarize consumers with a particular certifying body, and to build their confidence in the value of its certificate. Simply put, truthful advertising may inform consumers of the virtues of a particular certification.

The infertility field again provides an illustration of the difficulties experienced in developing appropriate certification of processes and organizations. I am advised that there is more than one board providing certifications, including certificates based on certain minimum performance standards. Membership in these various organizations may not necessarily be mutually exclusive. However, if any consumer were to try to compare the services offered by physicians for the treatment of infertility, they might try to compare them based upon membership in, or certification by, different organizations. I am not rendering any final judgments here, but rather simply recognizing the

difficulty in developing certification methods that serve consumers' needs for accurate information, and noting the educational benefit that additional advertising by the certifiers might have.

The growth of specialization in health care markets, and the parallel increase in certification efforts indicates that regulators, whether public boards or private associations, may need some latitude to develop preventive measures against misleading or deceptive information, which can be implemented with reasonable efficiency. At the same time, regulators must distinguish between truthful and deceptive ads; arbitrary rules suppressing broad categories of truthful advertising are "overkill" weapons against deception. Except in cases involving "state action", the Commission staff will continue to examine restraints on advertising specialization and certification, with due regard to balancing the need to prevent deception, with consumers' interests in receiving truthful and relevant information.

A collateral area to information restraints involves referral fees. As economists at the Commission and elsewhere have indicated, referral fees can be a marketing tool to attract new customers, just as advertising can be. However, referral fees raise issues not found in analyzing advertising. First, there may be conflict-of-interests issues presented. When there

is a fiduciary relationship between a professional and a client, in the health care field or elsewhere, receipt of a referral fee from a third party to whom a professional refers the client raises the possibility of a conflict between the professional's pecuniary interests and the client's. Second, there may be disclosure issues generated by referral fees. Specifically, when there are payments of referral fees to attract clients, should disclosure of such fees be required, and does such disclosure effectively and completely cure any conflict-of-interest problem?

Resolution of these issues requires careful analysis of consumers' interests in avoiding deception or overreaching, and at the same time analysis of the consumers' interest in obtaining useful information. Accepting a fee for a referral has long been considered unethical in many professions, including many health professions, and in my own, the legal profession.

Although some of my fellow Commissioners and I do not always agree in this area, I believe that, in certain instances, there may be plausible efficiency arguments in favor of professional associations proscribing such referral fee payments under ethical codes. When a doctor prescribes a product or service, or refers a patient to another practitioner, for example, the patient may be entitled to assume that the referral is based on a disinterested evaluation of the patient's needs, and not on who has offered the physician the highest fee for the patient's business. When a

professional association bans such referral fees, not only is the potential conflict of interest eliminated, but public confidence in the integrity of the profession is preserved. The key question, of course, is whether there is sufficient economic evidence to justify the government in overturning a ban that may create efficiencies ultimately benefiting consumers. For this reason, referral fee restrictions must be considered on a case-by-case basis, with a thorough analysis of the economics of the particular profession, and the group involved.

The Commission recently accepted a consent agreement with the American Institute of Certified Public Accountants, the largest professional association of accountants. The complaint in that case alleged that certain of the AICPA's restrictions on referral fees violated Section 5 of the FTC Act. In accepting the consent that bans such restrictions, except to the extent that they require full disclosure, the Commission apparently was not persuaded that acceptance of referral fees by accountants in non-attest cases creates sufficient conflict of interest, to the detriment of consumers, to justify an ethical limitation of this nature. Along with Commissioner Azcuenaga, I dissented from this decision. In my judgment, insufficient economic evidence was submitted to buttress the Commission's action, particularly on the question of whether disclosure is a cure-all. This stands in

stark contrast to areas such as advertising bans, where substantial economic evidence is available.¹⁷

The AICPA consent covers both intraprofessional referral fees and payments to those outside the profession, such as organizations engaged in the business of operating a referral service. The latter may not raise the same dilemmas as to breach of fiduciary relationship and conflict of interest. Referral services collect information on various practitioners, and attempt to match prospective patients with practitioners who satisfy their requirements. In some cases, these services may be financed by payments made by the patient; often they are supported by fees paid by the practitioners. While there may be some potential for abuse in the absence of disclosure, such services can provide vital information that consumers may otherwise find very difficult to obtain. Consequently, onerous restrictions on their operations may amount to a restraint on the dissemination of information, with attendant harm to consumers. These cases will have to be analyzed with great thoroughness by the Commission, with considerable focus on the economic facts in each case. I anticipate that you may be seeing further direction from the Commission in this area, in the not-too-distant future.

¹⁷ Cf., Calvani, Langenfeld, & Shuford, Attorney Advertising and Competition at the Bar, 41 Vand. L. Rev. 761 (1988) (economic justification for prohibiting certain advertising restrictions).

CONSPIRACIES TO BOYCOTT AND TO FIX PRICES

For years now, investigations of boycotts and price-related agreements have been a staple of our health care program, and the Commission undoubtedly will continue to prosecute those activities when we become aware of them. Overt efforts to coerce health coverage providers into raising fees by open threats of concerted departicipation by providers are unlikely, due to public awareness of past government enforcement in this area. For the same reason, we may also witness fewer efforts to prevent hospitals from opening satellite clinics through mass threats by medical staff to take their patients elsewhere. Clearly, these kinds of activities are not legal and, in fact, can result in criminal prosecution by the Department of Justice or action by the state Attorneys General. Indeed, the Department's recent victory in the Alston case¹⁸ underscores the substantial risk of criminal prosecution for those engaging in such activities.

This is not to say, of course, that concerted efforts to raise prices or to thwart innovative entry are creatures of the past. But, by and large, our staff expects such efforts to become more subtle and sophisticated in design and execution. Opposition to new entry may more often take the form of foot-dragging and subtle implications that unspecified adverse consequences will flow from actions not popular with members of the profession; such opposition may ostensibly be premised on

¹⁸ United States v. Alston, CR 90-042-TUC (D. Ariz.).

grounds other than competition. In these kinds of cases, it is more difficult to prove an agreement to restrain competition. It is settled law, however, that an agreement can be inferred from circumstantial evidence, and in compelling instances, the Commission may rest its cases on such evidence, where it is reliable and is in sufficient quantity. Moreover, the Commission can be expected to critically examine proffered efficiency justifications, to determine whether they have substance, or are simply pretexts for limitations on competition.

Many price-fixing conspiracies may likewise been driven underground. Some may be simply better concealed; others may take the form of concerted negotiation by organizations purporting to be integrated joint ventures. The Commission must tread carefully in evaluating the actions of arguably integrated groups to avoid discouraging legitimate attempts to meet market demands for more efficient health-care delivery arrangements. I will, however, take a careful look at whether these organizations are in fact attempting to resist market pressures under the guise of establishing a new competitor in the market.

These issues may arise, for example, in cases involving joint price negotiations with third-party payers by groups of providers purporting to be independent practice associations or preferred provider organizations. IPAs and PPOs are usually legitimate joint ventures, and price-related agreements may be

ancillary to an efficiency-enhancing partial integration of their members' professional practices. In some situations, though, the IPA or PPO label may be used by groups of independent providers who combine merely for the purpose of negotiating uniform rates of reimbursement from payers, and agree that none of them will accept less than the price that is acceptable to all. These kinds of arrangements will be treated as the per se illegal price-fixing agreements that they are.

While some so-called IPAs or PPOs may be merely a guise for price-fixing and involve no integration or other indicia of efficiencies whatsoever, other IPAs or PPOs, for instance, may provide for some productive integration of their members. Under the framework for evaluating horizontal restraints adopted by the Commission in Massachusetts Board of Registration in Optometry,¹⁹ otherwise suspect agreements may be permissible if they promote the efficiency of a joint venture by, for example, reducing costs or creating a new product or service. Where integration, and its related efficiencies, are cited as justification for an ancillary price restraint among IPA or PPO members, a crucial question in evaluating that price agreement is whether the agreement not only accompanies, but is reasonably related to, the efficiency claimed, to justify it. Therefore, the Commission has looked not simply at the type of integration and risk-sharing undertaken by the IPA's or PPO's members, but at the relationship between that

¹⁹ 110 F.T.C. 549 (1988).

integration and the price agreement. In other words, how is the price agreement necessary to make the joint venture work efficiently? Prospective efficiencies are not a persuasive justification for an otherwise illegal agreement on price if such efficiencies could be accomplished without a price agreement.

HOSPITAL JOINT VENTURES OR "NETWORKS"

Recent years have seen the emergence of a variety of hospital joint ventures. Joint ventures, networks, or alliances have long been attractive mechanisms for individual hospitals to obtain efficiencies similar to those enjoyed by multi-hospital systems. Traditionally, these relationships have joined non-competing hospitals into large-scale groups capable of engaging in group purchasing and sharing certain services, such as education and training, economic forecasting, and consulting. On the local level, smaller groups, often including competitors, have engaged in a variety of shared-service arrangements, typically including imaging technology, laboratory facilities, and laundry or food services. These arrangements generate obvious efficiencies, and even when they involve competitors, generally have not raised serious antitrust problems.

Recently, some hospitals have entered into local hospital networks that go beyond the familiar shared-service arrangements, and into potentially sensitive competitive areas of joint marketing, joint planning and joint negotiating with third-party

payers. As horizontal agreements relating directly to competitive strategy, these raise possible antitrust concerns.

Assume, for example, a network involving several hospitals in a large metropolitan area where the market concentration of hospital services approaches the "moderately concentrated" standard of the Justice Department Merger Guidelines. The hospitals form a network parent corporation that is contractually granted control over the sponsors' budgets, major acquisitions and strategic plans. The objectives of this network include the negotiation of managed care contracts, reduction of inefficient duplication of various inpatient services and technological expenditures, enhancement of the network's image, and coordination of strategic planning. Members are required to contract with third-party payers and managed care systems through the parent, unless the parent is unable to do so.

Commission staff will be looking at a number of issues that individual arrangements of this nature may present. First, is the arrangement an acquisition or joint venture reportable under the Hart-Scott-Rodino Antitrust Improvements Act? Second, are the activities undertaken sufficiently integrated to avoid summary condemnation of the horizontal restraints imposed? Third, what are the purposes of the venture, and are the horizontal restraints necessary to achieve those purposes? Fourth, what are the likely anticompetitive effects of the

horizontal restraints? Are they outweighed by any likely procompetitive effects?

As this example suggests, the restraints can be quite significant. A detailed economic analysis of the market, and of the operation of the network, is needed to evaluate and balance the likely procompetitive and anticompetitive effects of particular arrangements. Clearly, the extent of horizontal coordination raises some hard issues.

Other networks may involve joint market research, marketing, data-gathering and administrative functions. For example, some networks analyze purchasers' health benefits expenses and provide that information to their participants, who can then bid to provide a given volume of one or more services at a pre-established or unit price. The network may also help develop, or encourage its members to develop, pricing methodologies. Obviously, networks of this type can raise complicated questions relating to sharing of price information and the facilitation of common pricing, and must be carefully analyzed on a case-by-case basis.

The growth of hospital networks -- both in number and in variety -- is a recent phenomenon, and the Commission's staff has just begun to consider some of the issues that they present. Many of the restraints imposed by such networks are complex, and

can create both procompetitive and anticompetitive effects. All of those effects must be examined, understood and balanced in order to determine which of these "Teenage Mutant Ninja" arrangements may have an overall anticompetitive impact in the relevant market.

CONCLUSION

In conclusion, it could be fairly said of the FTC's health care program that much has been accomplished; but, with the various issues raised by sophisticated developments in the industry, much remains to be done. Many of the fundamental issues have been resolved: naked restraints on price competition or advertising are now few and far between. In general, what we encounter today are restraints that are not facially anticompetitive, and that require a more careful economic analysis of their competitive effects than was necessary in the past. But while changes in the marketplace and the increasing antitrust sophistication of providers may have affected FTC enforcement priorities, our basic mission remains the same. As before, we will take vigorous action against activities that unreasonably restrain competition, while avoiding government interference with beneficial innovations by health care providers.