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THE ROLE OF ANTITRUST ENFORCEMENT

IN HEALTH CARE REFORM

Remarks of

Janet D. Steiger
Chairman
Federal Trade Commission

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National Health Lawyers Association
Program On
Antitrust in the Healthcare Field

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

I want to thank the National Health Lawyers Association for inviting me to speak to you about the Federal Trade Commission's antitrust law enforcement activities in the health care area. This is the second time I have had the pleasure of addressing you as Chairman of the Commission. As always, the views I express are my own, and do not necessarily represent those of the full Commission or of my fellow Commissioners.

There is intense interest in proposals for containing the rapidly increasing cost of health care in the United States. I am not going to discuss any particular proposal, but as Chairman of an agency that has for years been an active advocate and defender of competition in health care, I do want to address an element that figures prominently in various proposals -- reliance upon competition among managed care plans.

I have two principal points. First, antitrust enforcement by the Commission and others was one of the factors necessary to the creation of managed care plans. Antitrust cases eliminated anticompetitive rules against physician affiliation with such plans, and halted boycotts against varying new health care arrangements.

Second, a vigorous antitrust presence is likely to be equally important to the success of any competition-based model for the health care sector. I am not going to suggest that any particular antitrust exemption would doom any particular health care reform plan. However, statutory antitrust exemptions that are now being advanced by some provider groups could permit behavior that injures both consumers and the economy as a whole.

The foundation of the reform proposals that emphasize managed care is the proliferation of plans that have arisen due to dissatisfaction by some consumers (including employers that provide health benefits) with the way in which the prevailing health care system functioned. This array of plans can be seen as the fruits of the competitive process. We at the FTC did not create the plans; that is not our job. We did our job of protecting competition, and the plans grew in response to consumer demand for quality care at more affordable prices.

In light of various legislative proposals for antitrust exemptions for physicians and hospitals, let me focus today on situations where physician boycotts obstructed plan development and where hospital mergers threatened the ability of plans to obtain savings for their members. I have a few preliminary observations, however, reflecting in part the breadth of issues in the health care field. For example, the Commission has brought enforcement actions to prevent unjustified restrictions on non-physician providers, who offer somewhat different services at sometimes lower prices.[1] However, we do not play favorites, and recent cases show that we also proceed against non-physician groups when we believe that their actions harm consumers.[2] We do

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[1] For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Corp., 102 F.T.C. 1232 (1983)(consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986)(consent order)).

[2] American Psychological Ass'n, C-3406, 58 Fed. Reg. 557, (1993)(consent order); National Ass'n of Social Workers, File No. 861-0126, 57 Fed. Reg. 61,424 (1992)(proposed consent order).

seek to ensure that physicians and non-physicians alike can compete on a level playing field. The resulting competition benefits both managed care plans and individual consumers.

The Commission has brought other important health care cases. Last year, the Commission issued an order preventing the Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to other services.[3] The Department of Veterans Affairs estimated that without the tie-in it could save $20 million a year. Another tie-in case prevents renal dialysis clinics from circumventing Medicare reimbursement limits.[4] The Commission continued to act against alleged boycotts -- including a nursing home boycott of registries that employ temporary nurses,[5] and pharmacy boycotts to prevent cost containment.[6] Finally, two leading manufacturers of infant formula recently settled Commission charges of anticompetitive conduct by agreeing

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[3] Sandoz Pharmaceutical Corporation, No. C-3385, 57 Fed. Reg. 36,403 (1992)(consent order).

[4] Gerald S. Friedman, No. C-3290, 55 Fed. Reg. 27,686 (1990)(consent order).

[5] Debes Corp., No. C-3390. 57 Fed. Reg. 39,205 (1992)(consent order).

[6] E.g., Southeast Colorado Pharmacal Ass'n, No. 911-0101 (October 29, 1992)(consent order accepted for public comment); Peterson Drug Company, No. D-9227 (1992); Chain Pharmacy Ass'n, No. D-9227, 56 Fed. Reg. 9,223 (1991)(consent orders) Orange County Pharmaceutical Soc'y, No. C-3292, 55 Fed. Reg. 31,441 (1990)(consent orders).

to provide restitution to the U.S. Department of Agriculture in the form of free infant formula.[7]

I also have a general caveat. Although antitrust enforcement has been important to health care reform, I don't think that any one agency or any single discipline holds all the answers here, and the ongoing process promoting cross-fertilization of ideas will be vital. For my part, I intend to work to maximize opportunities to provide guidance as to our thinking outside of the adversarial litigation process.

I. The Contribution of Antitrust Enforcement to the Development of Managed Care Plans

To understand the role antitrust enforcement has played in opening the medical marketplace to new forms of competition, it is useful to start with a retrospective look. For a good part of this century, most physicians simply practiced solo, fee-for-service medicine. There were virtually no "alternative" arrangements. Even multispecialty group practices were rare, and any innovative health care plans that sought to compete by signing up a limited panel of quality physicians were impeded by a variety of restrictions. Most hospitals operated in a similar fashion, with few limitations on what they could charge. Those hospitals with contractual arrangements to provide services --

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[7] FTC v. Mead Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992). The Commission is also pursuing allegations of price fixing against a third manufacturer. FTC v. Abbott Laboratories, 1992-2 Trade Cas. (CCH) ¶ 69,996 (D.D.C. 1992).

for example with Blue Cross plans, which began in the late 1930's -- usually were paid on a "cost-plus" basis.

Forerunners of today's managed care arrangements developed in some areas, but they often met opposition from "mainstream" providers. Thus, physicians who associated with such plans were often the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges.[8] In 1943 the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early HMO-type plan.[9] The associations had brought disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and took actions against hospitals that permitted Group Health doctors to practice there.

Until 1975, when the Commission initiated a legal challenge to them, the AMA's ethical standards prohibited physicians from entering into the kinds of contracts that are needed for managed care plans. These restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or HMO, "underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the

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[8] See P. Feldstein, Health Associations and the Demand for Medical Care 40-44 (1977).

[9] American Medical Ass'n v. United States, 317 U.S. 519 (1943).

"usual" fees in the community, or entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. Thus, physicians risked censure by medical associations if they participated in HMOs or other managed care-type plans which, like today's PPOs, limited provider participation and competed on the basis of price.

In 1979, the Commission found these restrictions on "contract practice" illegal,[10] and this decision made it easier for physicians to participate in offering innovative forms of practice. The advertising aspect of the Commission's AMA case also benefited managed care plans. As you will recall, doctors had been prohibited by "medical ethics" from disseminating truthful information to the public about the price, quality, or other aspects of their services (such as office hours, acceptance of Medicare assignment or credit cards, use of Spanish-speaking staff, or house-call services.)[11] The Commission found that this ban on truthful advertising had a particularly adverse impact on innovative plans such as HMOs; such plans had more need to advertise precisely because they were new.[12]

After the Commission's AMA case freed physicians to enter into contractual relationships with health care plans, such plans

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

[11] E.g., American Medical Ass'n, supra, 94 F.T.C. at 846-48; Broward County Medical Society, 99 F.T.C. 622, 624 (1982) (consent order).

[12] American Medical Ass'n, supra, 94 F.T.C. at 1006.

faced a different sort of hurdle -- boycotts by provider groups. While some providers are enthusiastic about joining managed care plans, and many others are content to compete against them on the merits, our experience shows that some providers have been prepared to engage in illegal concerted action to resist new forms of competition. The Commission has banned such conduct as denying participation in Blue Shield to physicians working for an HMO,[13] obstructing hospital privileges for HMO physicians,[14] and boycotting a hospital that was planning to open an HMO facility.[15]

Antitrust continues to play an important role in the health care field. For example, the Commission recently issued orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic. The clinic is a multispecialty group that prices its services in an innovative way, charging a "global fee" or "unit price" that covers all aspects of many services, such as surgery.[16]

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[13] Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976)(consent order).

[14] Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979)(consent order).

[15] Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988)(consent order).

[16] Medical Staff of Holy Cross Hospital, C-3345, 56 Fed. Reg. 49,184 (1991)(consent order); Medical Staff of Broward General Medical Center, C-3344, 56 Fed. Reg. 49,184 (1991) (consent order); Diran Seropian, M.D., Dkt. No.9248, 57 Fed. Reg. 44,748 (1992)(consent order).

The history of the relationship between the medical profession and the insurance industry also merits attention. The first medical and hospital prepayment plans -- forerunners of today's Blue Cross and Blue Shield plans -- were outgrowths of state or local medical societies and hospital associations. These groups initially had direct control of the plans, but in the early 1970's the Blue Cross plans began to split off from the hospital associations. Provider control of Blue Shield plans lasted longer, until concern about antitrust liability and other factors led to reform. An important factor in the debate about provider control of Blue Shield plans was a Commission staff report detailing evidence that medical societies had used control of the plans to increase physicians' fees and to obstruct competition from non-physician providers and from health care plans.[17]

One of the first Blue Shield plans to become independent of a medical society was Blue Shield of Michigan. Once independent, this plan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In Michigan State Medical Society,[18] the Commission found an antitrust violation and

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[17] Medical Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission (1979).

[18] 101 F.T.C. (1983).

banned all such "negotiations." The Commission has also enjoined numerous other conspiracies to obstruct cost containment.[19]

II. The Relationship of Antitrust to Health Care Reform

Just as antitrust law has so far been crucial to growth of alternative arrangements in the health care sector, so it is likely to prove necessary to the success of future reform, including proposals that rely on managed care or "managed competition." Experience in health care markets has shown that, without the protection that antitrust law provides, markets sometimes tend toward less competition and less responsiveness to consumers. Vigorous antitrust enforcement can help ensure that change responds to market forces and thus reflects consumers' wants and needs.

Nonetheless, we have recently been seeing a variety of proposals to create special antitrust exemptions for collective action by physicians and hospitals. The proposals concerning physicians would exempt various forms of concerted action -- in particular, collective negotiations with health care purchasers and payors. The proposals concerning hospitals would exempt mergers and various kinds of joint ventures. I am not going to get into the specifics of any proposal, but I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and hospitals may be based on faulty premises about the nature of

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[19] E.g., Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447 (1986). See also Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992)(consent order).

competition in health care and how antitrust law applies to physicians and hospitals. One premise is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other premise is that antitrust law is not flexible enough to deal with markets, such as health care, that do not resemble perfect competition. In my view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with joint conduct that is truly justified.

This is the second major attempt to carve out a special exemption in this area. In the early 1980's, there was a campaign to exempt all state-licensed professions -- most notably, physicians and dentists -- from all of the provisions of the Federal Trade Commission Act. The exemption was vigorously opposed by a unanimous Commission. It was also opposed by the Reagan Administration and by such provider groups as the American College of Physicians, the American Nurses Association, and the American Psychological Association.[20]

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[20] Among the other groups opposing the exemption were the American Podiatry Association, the American College of Nurse Midwives, the National Association of Optometrists and Opticians, the American Society of Allied Health Professions, the American Association of Nurse Anesthetists, and the American Dental Hygienists Association.

The exemption proposal of the 1980's was eventually defeated in Congress by a bipartisan coalition. The debate was vigorous then and I expect it will be again.

The current campaign for an antitrust exemption for physicians focuses on physicians' dealings with purchasers and payors of health care services. Today, if there are no anticompetitive restraints on competition, physicians compete to be selected by one or more plans; this competition among physicians is how the plans ensure that they have enough quality physicians, without paying unnecessarily high prices. The proposed exemption would permit otherwise competing physicians to eliminate this competition by joining together and, without engaging in any efficiency-enhancing integration of their practices or finances, collectively bargaining with "market dominant" purchasers and payors. While at first blush this proposal might appear reasonable on "fairness" grounds, as the song says, "It ain't necessarily so."

These so-called "dominant" payors seem to be any plans with sufficient clout to bargain aggressively with physicians and other health care providers to obtain better deals for consumers. Purchasers and payors that represent a large number of consumers are in a position to insist that providers agree to lower charges for their services, and adhere to a variety of cost-containment measures, if they want to participate in a plan and have access to the plan's patients. An exemption allowing sellers of health

care services to aggregate for bargaining purposes might enable them to defeat cost containment efforts.

In addition, there has been no clear demonstration that even large purchasers or payors have market power. In every state, there are Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits, and self-insurance is also available to many. Consumers seem to have lots of choices. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but rather unconstrained market power. Moreover, even if large payors did have market power, it does not necessarily follow that permitting physicians to obtain market power would benefit consumers. Economists generally agree that you cannot reliably fight market power with market power.

We don't need to rely on theory. We have seen what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the Michigan State Medical Society case I mentioned, because the plan in that case -- one of the largest Blue Shield plans in the country -- functioned much like a managed care plan. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but many physicians agreed that they would not compete among themselves over the terms they would accept

from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society. The Commission enjoined these "collective negotiations," but it emphasized that the association could provide information to the plan -- including fee information -- so long as it did so without the boycott threat that is implicit in "negotiations."

I want to emphasize that no antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients; that is clearly legal under the antitrust laws. But as the Commission's cases make clear, the judgment of health care providers concerning what patients should want can differ markedly from what the patients themselves are asking for in the marketplace. Perhaps the most dramatic illustration was the Indiana Federation of Dentists case, where the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program that had been introduced in response to consumer demand. The Court rejected the argument that providers should be able to "protect" patients by imposing the providers' will on the market and thus denying patients choice. In the words of the Court, the antitrust laws do not permit a group of providers to "to pre-empt the working of the market by deciding for itself that [patients] do not need that which they demand."[21]

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[21] 476 U.S. at 462.

The lesson is fairly simple. Physicians can engage in forceful and effective advocacy or provide information to health plans without an antitrust exemption. But an antitrust exemption for "collective negotiations" could permit boycotts that override consumer choice and harm our economy.

Consideration is also being given to a special antitrust exemption for hospitals. Here, two arguments are advanced. First, advocates contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers or joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. We must ask whether either argument is justified by the facts.

At the outset, I should note that the great majority of hospital mergers and joint ventures -- like those in any line of business -- do not endanger competition. The vast majority of hospital mergers occur in metropolitan areas, and many of these raise no antitrust concerns due to the existence of numerous competitors. In addition, many hospital mergers may enhance efficiency and promote competition. Similarly, hospital joint ventures frequently are efficiency-enhancing, especially when they are designed to make a new and expensive technology available to a community, and are narrowly focused on those

hospital operations where combining resources is likely to result in reduced costs and/or better service.

The Commission's record reflects our awareness of these realities. In a typical year, there are about 50-100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted about two dozen formal investigations, mostly involving larger metropolitan hospitals, and has challenged, on average, less than one hospital merger a year.

Nor should the antitrust enforcement record on hospital joint ventures evoke concern. The Commission has not challenged a single joint venture among hospitals.[22] And we have gone out of our way to identify specific types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order against a hospital merger, the Commission expressly exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide

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[22] The possibility that the efficiency goals claimed for a merger could be achieved through a less anticompetitive joint venture is a factor considered by the Commission in deciding whether to challenge the merger.

data processing, laboratory testing, and health care financing.[23] These joint ventures were of the type likely to achieve efficiencies and improve specific services, but without endangering price and quality competition for other services, as a merger would.

In light of this record, it may not be surprising that most hospitals engage in some forms of joint venture activity, and hospital merger activity has been so vigorous that a recent article in Modern Healthcare was entitled "Mergers Thrive Despite Wailing About Adversity."[24] The record does not provide a basis for the claim that antitrust law has prevented efficient consolidations or joint ventures.

I also want to address the argument that competition among hospitals is "bad" because it just leads to costly duplication of services and facilities. This same argument was made to the Commission by Hospital Corporation of America, and the Commission found in that case that it was contradicted by a great deal of evidence, including, among other things, internal hospital documents saying such things as "increasing competition in the health care sector . . . will allow natural market forces to slow

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[23] University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) (consent order). See also The Reading Hospital, FTC Docket No. C-3284, 55 Fed. Reg. 3264, 3266, 15,290 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory and biomedical equipment repair services).

[24] Modern Healthcare, Oct. 12, 1992 at 30.

the price spiral."[25] Moreover, claims that competition simply leads to costly duplication are often responded to by managed care programs, which tell us that competition among hospitals is important because it permits them to get better deals for consumers.

I return here to my theme about the relationship between antitrust enforcement and managed care plans. The growth of managed care plans is an important reason why competition now constrains cost increases in the hospital sector. As Judge Posner said in the HCA case, one way hospitals can resist the current pressure to cut costs is by "presenting a united front."[26] When we review hospital mergers, an important consideration is whether the merger will help or hurt payors and managed care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, monopoly hospitals or hospital chains may be better able to resist such cost-containment efforts.

III. Conclusion

In sum, the current focus on reform in health care presents both opportunities and risks. Despite some imperfections, competition in health care markets has provided important consumer benefits, and antitrust enforcement has been vital to the emergence of the managed care plans with their procompetitive

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[25] Hospital Corp. of America, 106 F,T.C. 361, 478-87 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

[26] Hospital Corp. of America v. FTC, 807 F.2d at 1389.

potential. One must ask if antitrust exemptions for health care providers could be a step backward that harms consumers by hindering effective competition.