Federal Trade Commission

ANTITRUST AND MANAGED COMPETITION FOR HEALTH CARE

Prepared Remarks of

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All of us, I am sure, are anticipating the unveiling of the Administration's health care plan. While the essentials of the plan have not been released, there has been considerable publicity and much discussion of the broad principles of "managed competition" that press reports suggest might underlie the actual plan.[1] I have no special knowledge of what the Administration intends, but, as I understand it, managed competition generally describes a regulated market place wherein health plans compete for clients on the basis of price and quality.[2]

There is great promise associated with a health care policy that acknowledges the special features of the health care market and intervenes into this market in a way designed to take advantage of the benefits of competition. At the same time, the success of such intervention may depend crucially on whether competition will operate according to expectations. It is this concern that makes appropriate antitrust policy important, and will be the subject of my remarks.

I will discuss the implications of managed competition for the structure of health care markets and the role for antitrust. My main point is that maintenance of competition via the antitrust laws seems a *sine qua non* of managed competition. The

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[1]The nomenclature for the concepts of the plan may change. For the purposes of this talk, I will use the terms that have been discussed in the press.

[2]There are several variants of managed competition proposed. See, for example, P. Ellwood, A. Enthoven, and L. Etheredge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," Health Economics Vol. 1 (3), 149-168 (1992); J. Garamendi, California Health Care in the 21st Century: A Vision for Reform, Insurance Commissioner, State of California, February 1992.

guiding principle of managed competition is that separate groups of providers should compete against each other to provide health care to consumers. The antitrust laws would enable this principle by preventing monopoly, collusion, and undue barriers to new entry into markets. My second and subsidiary point is that changes in the structure of health care markets are likely to create new challenges for antitrust policy, including merger policy and policies regarding exclusive dealing with respect to provider organizations.

Before turning to these two points, I will review the broad outlines of managed competition as reported in the press, identify some important features of health care markets, and review briefly FTC policy towards health care markets.

I. What is managed competition?[3]

Advance publicity suggests that managed competition will for the most part be competition for managed care contracts. This much is familiar. Most insured Americans already have health plans with some managed care features. These features include limited or preferred panels of providers, new financial incentives for providers and patients, and utilization review.

One new element of managed competition proposals are the HIPCs - Health Insurance Purchasing Cooperatives. HIPCs would be quasi governmental bodies intended to contract for health plans on behalf of large groups of consumers, especially those who are

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[3]See, for example, "What is 'Managed Competition'?" Investor Daily, April 5, 1993.

currently uninsured, or perhaps even on behalf of all consumers.[4] The HIPCs reportedly would offer consumers a menu of competing health plans, probably with a standard package of benefits, and possibly with differences in price and aspects of quality. The HIPCs would have administrative, bargaining and regulatory functions, but probably not an insurance function.[5] Finally, HIPCs or some other organization would evaluate the quality of competing health plans, and publish a "scorecard" that makes comparison shopping by consumers easier.

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[4]Some states have already enacted health plans with many of the characteristics discussed here. For example, Florida recently created 11 regional "Community Health Purchasing Alliances" to negotiate with insurers and medical providers. Wall Street Journal, April 5, 1993, B8.

[5]Although aspects of regulation feature importantly in managed competition proposals, my remarks focus on issues surrounding competition in health care markets. The details of what role HIPCs will play as regulators are still very much up in the air, but a number of ideas have been discussed. One important regulatory function that HIPCs may have is adjusting payments to each plan based on the risk profiles of their subscribers. The purpose would be to discourage the design of health plans that attract only relatively healthy subscribers. Another possible regulatory function is "global budgeting," which could take various forms, including across the board price controls. A particularly simple form of global budgeting is to place caps on the per capita premiums health plans can collect. This would give health plans an incentive to reduce their costs, assuming the HIPCs could commit to the premium caps for a sufficient period to enable health plans to recoup investments in cost reduction. Such a proposal is a cousin to "price cap regulation" that has been adopted in telecommunications markets recently. A third important regulatory function the HIPCs (or other regulatory organizations) are likely to have is to set and monitor quality standards. This is obviously important to prevent price cap regulation from creating incentives for cost reduction via quality degradation.

Some proponents believe that HIPCs would encourage the formation of large vertically and horizontally integrated networks of providers that act as *de facto* insurance companies by providing prepaid health care.[6] Given a standardized package of benefits, the composition of the network would essentially define a health care plan. It would probably include one or more hospitals, specialists and a large panel of primary care physicians. It may also include diagnostic facilities, laboratories, nursing homes, home health agencies and other providers. It is expected that network-based health plans would contract with the regional HIPC and other sponsors on a capitated basis. This means the network as a whole would receive a fixed annual payment per capita to provide all of the covered health care needs of its clients. In other words, a health care network would function much like a traditional HMO.

The formation of large provider networks would be a continuation of trends we already see. The alphabet soup of HMOs, PPOs, IPAs, and PHOs refers to various forms of provider integration that are in the marketplace. Capitated payments are not new either. This feature already characterizes many existing provider organizations, such as HMOs, but it is likely to be much more important, if not ubiquitous, under managed competition.

I expect health plan competition on a capitated basis to be a driving force for further consolidation and integration. This

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[6]Such organizational arrangements are referred to as Accountable Health Plans. See e.g. "A Health Care Primer," The Washington Post, March 9, 1993, A1.

could happen in various ways. Provider networks might integrate forward into health care financing by offering complete health plans directly to HIPCs and other sponsors. Or insurance companies might integrate backward into health care provision by acquiring or contracting with provider groups.

Provider networks are expected to achieve significant economies of scale and scope resulting in lower costs of providing care. These include economies of shared services, coordination economies, and improved organizational incentives for the delivery of cost-effective care. Hopefully, HIPCs and other large sponsors can pass efficiencies from the formation of integrated provider networks on to consumers, by forcing provider networks to compete on price and quality. I think antitrust policy has a role to play here, but I will return to this point later. For the moment, though, I would like to lay some groundwork, by discussing in more detail certain key features of health care markets.

II. Features of health care markets

Under managed competition proposals, all health plans would be required to offer all consumers a basic package of benefits. However, it is important to recognize that this contract would be incomplete, as are all health insurance contracts. A health insurance contract specifies that a patient will receive treatment for some diagnosis, but it does not say exactly what that treatment will be or how it will depend on the patient's exact condition. Details are left to the patient and physician.

However, the decisions made within this relationship are shaped by the various constraints and financial incentives defined by the patient's health care plan.

Managed care is a relatively recent phenomenon that emerged in response to problems inherent in a system of insurance plans that paid providers a "fee-for-service," exemplified by traditional Blue Cross and Blue Shield policies. The "fee-for-service" system encouraged demand for more and better health services resulting in spiralling and ultimately, for some, unaffordable costs. Managed care insurance plans such as HMOs and PPOs were a market response to this problem.

A well-understood problem with health insurance plans is that a third party pays the bill, so that neither the physician nor the patient internalizes the cost of their decisions. This is not necessarily a bad thing. Indeed, the whole purpose of health insurance is to shift the risk of uncertain health care costs away from the risk-averse patient to the insurance company. The problem is that the patient, insulated from price, demands more health care treatment than is cost-effective. And the patient's physician, who is reimbursed for her services while insulated from the price of other services she orders or referrals she makes, perhaps concerned about malpractice claims, and feels an ethical responsibility to provide the best available care to her patients, is happy to accommodate the patient's demand. The result is costly health care that is paid for

initially by insurance companies, but ultimately passed on to consumers and their employers in the form of higher premiums.[7]

This problem is ameliorated by changing the financial incentives of the patient and the physician. Requiring copayments makes patients more price sensitive, but the problem of excessive demand is corrected only in proportion to the size of the copayment. Requiring physicians to bear some risk associated with costly treatment decisions can be expected to have some but perhaps a limited effect as well. The positive risk-bearing effect is limited because the risk-sharing features of physician organizations like IPAs suffer from a free-rider problem. Since risk is shared, the individual physician bears only a small consequence of her own treatment decisions, too small perhaps to fully overcome a physician's incentives to accommodate the excessive health care demands of her patients.[8]

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[7]A further possible problem identified in the literature is called the "medical arms race." See, e.g., J.C. Robinson and H.S. Luft, "The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care," 4 Journal of Health Economics 315-25 (1985). The argument is that hospitals invested in better and better technology to encourage physicians to send their patients to that hospital; these technology expenditures were then passed through by cost-based retrospective reimbursement rules. While some claim that the medical arms race is exacerbated by local competition, a recent study found minimal evidence for this effect among California hospitals. David Dranove, Mark Shanley, and Carol Simon, "Is Hospital Competition Wasteful?" 23 RAND Journal of Economics 247-62 (1992). Also, it is noteworthy that payors, including Medicare, have moved from retrospective to prospective reimbursement of hospitals with schedules of allowable prices or capitated payments.

[8]Although financial integration and, hence, evidence of risk-sharing is an important factor in determining whether a physician joint venture raises any anticompetitive concerns, see (continued...)

This is why the utilization review features of managed care matter. Utilization review amounts to third party oversight of the health treatment decisions made by the patient and his physician. This oversight determines what treatment decisions are covered by a patient's health plan. Thus, utilization review is intended to constrain the set of treatment decisions available to the patient-physician pair.[9]

Currently, different health plans featuring a variety of managed care provisions coexist in the market. Traditional fee-for-service plans have not been driven from the market either, even though they are substantially more expensive than

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[8](...continued)
Arizona v. Maricopa County Medical Society, 457 U.S. 332, 356 (1982) (condemning medical society program by which doctors agreed to maximum prices where, inter alia, there was no evidence of integration or risk-sharing); Hassan v. Independent Practice Assoc., 698 F. Supp. 679, 689-90 (D. Mich. 1988); Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order permitting integrated physician joint venture to, inter alia, collaborate on price), the rule of reason inquiry under which such joint ventures are analyzed looks at a variety of different factors including the purpose and actual restrictions and practices of the joint venture, the degree of integration and extent of market power, no one of which is always dispositive. FTC Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,982 at 48,988-89 & nn. 41 & 44 (Oct. 5, 1981). See also United States v. Massachusetts Allergy Society, 1992-1 Trade Cas. (CCH) ¶ 69,846 (D. Mass. 1992) (consent decree that restricts risk-sharing physician joint venture from discouraging or restricting physician members from negotiating or contracting independently with any third party payer).

[9]Limited or preferred panels of providers is another cost containment strategy. Competition to be a member of a panel can spur discounted rates in exchange for a larger volume of business. This factor by itself, however, cannot be expected to change the physicians' incentives to accommodate patients' demands for excessive care.

alternatives. These different organizational features of health care plans determine the treatment services patients ultimately receive, and different consumers are likely to have different preferences over organizational features for this reason. For example, many consumers are willing to pay higher premiums for a wider choice of providers. When given a choice, different consumers opt for different types of health plans.[10]

Different types of health plans potentially contribute to consumer welfare by satisfying a demand for organizational variety. There is no conflict between organizational variety and economic efficiency as long as the relative prices of different plans to consumers reflect their relative costs. In principle, a concern for organizational variety is complementary to concerns for cost containment and quality of care.

III. FTC activity in health care markets

The FTC has taken a lead in protecting a diverse and innovative market place. In fact, as Chairman Steiger has observed recently, FTC activity has been instrumental in

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[10]A recent Consumer Reports ("Are HMOs the Answer?," August 1992) study assessed consumer satisfaction with HMOs. The study noted that HMOs pay their primary care physicians in different ways. Sometimes physicians are paid a salary, other times a capitation payment, and still other times a fee-for-service. Generally, these modes were joined with some risk-sharing incentive for physicians to order care judiciously. Nevertheless, consumers expressed highest levels of satisfaction with fee-for-service arrangements. Consumer Reports concluded that "the kind and amount of medical care you receive is directly linked to the way your primary-care doctor is paid." This observation supports the idea that the variety of plans in the market place is supported by heterogenous consumer preferences for different kinds and amounts of medical care.

dismantling entry barriers against new managed care health plans.[11] In 1975 the Commission attacked AMA ethical restrictions that inhibited physicians from working for HMOs. And through the 1980's the Commission successfully challenged boycotts of managed care plans by provider groups. By opening the doors for managed care, these cases have laid the groundwork for managed competition.

More recently, the Commission has taken action to stop alleged illegal concerted action by some providers to resist new types of health care delivery organizations by obstructing hospital privileges for HMO physicians[12] and by boycotting a hospital that was planning to open an HMO facility.[13] The Commission has also moved to enjoin a number of alleged conspiracies to obstruct cost containment measures.[14] For example, the Commission challenged a physician organization (an

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[11]Prepared statement of Janet D. Steiger, Chairman, Federal Trade Commission, before the Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, United States Senate, concerning antitrust enforcement and health care reform, March 23, 1993; "The Role of Antitrust Enforcement in Health Care Reform," remarks of Janet D. Steiger, Chairman, Federal Trade Commission, before the National Health Lawyers Association Program on Antitrust in the Healthcare Field, Washington D.C., February 19, 1993.

[12]Dkt. No. 9248, 57 Fed. Reg. 44,748 (1992) (consent order) (alleging physician boycott of multi-specialty group medical practice that offers a predetermined "global fee").

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

[14]In FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986), the Commission successfully challenged an alleged conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers.

IPA) that the Commission alleged operated solely to raise the fees paid by HMOs that used the physicians services.[15] The Commission has also acted to halt alleged organized boycotts by associations of pharmacies and their members to thwart third-party-payor attempts at cost containment measures for their prescription drug benefit programs.[16] Finally, the Commission has challenged other provider practices that may increase health costs: last year, the Commission challenged Sandoz Pharmaceutical Corporation's practice of "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[17]

These non-merger antitrust enforcement activities -- as well as FTC's hospital merger enforcement activity -- have had a beneficial impact on health care markets. I personally believe that, overall, antitrust principles provide sound guideposts for the efficient operation of markets. Thus, to the extent that health policy depends on competition, protection of competition -- antitrust enforcement -- is called for.

IV. Antitrust problems in a managed competition environment

Before delving into the precise nature of the antitrust issues raised by various reform proposals, one note of caution

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[15]Southbank IPA, Inc., Dkt. No. C-3355, 57 Fed. Reg. 2913 (1992).

[16]Southeast Colorado Pharmacal Ass'n, Dkt. No. C-3410, 57 Fed. Reg. 52,631 (1993); Peterson Drug Company, Dkt. No. D-9227 (1992) (Commission adopted opinion of administrative law judge after appeal withdrawn).

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

should be raised. Depending on how managed competition is actually structured, certain activities of provider networks might be exempt from the antitrust laws under the McCarran-Ferguson Act, which creates an exemption from the antitrust laws for activities that constitute "the business of insurance," if those activities are regulated by the states and do not involve boycott, coercion or intimidation.[18] Unless the McCarran-Ferguson Act's operation were expressly displaced by a new federal law, McCarran-Ferguson might limit the applicability of the antitrust laws to certain conduct of provider networks, although the test of whether an entity's conduct falls under the Act is highly fact specific.[19]

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[18]15 U.S.C. § 1012(b).

[19]Compare Ocean State Physicians Health Plan v. Blue Cross & Blue Shield, 883 F.2d 1101 (1st Cir. 1989) (The pricing, marketing and efficiency of HMO-type health insurance policies are within the business of insurance and thus exempt under McCarran-Ferguson) with Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1986) (decision by Blue Shield plan to refuse to pay for services rendered by clinical psychologists unless such services were billed through physicians did not fall within the business of insurance and thus was not exempt under McCarran-Ferguson). See generally, J. Miles, "The McCarran Act: Where It's Been and Where It's Going," in Developments in Antitrust Health Care Law 141 (1990). In 1983, the Commission accepted a consent order settling allegations that a physician-owned insurance company providing malpractice insurance had terminated the insurance of a physician because he had agreed to serve as a back-up physician to certified nurse-midwives. State Volunteer Mutual Insurance Corp., 102 F.T.C. 1232 (1983). It should also be noted that the Supreme Court is currently considering the scope of the boycott exception to the Act. Hartford Fire Insurance Co. v. California, Nos. 91-1111, 91-1128, 91-1131, 91-1146 (S.Ct. argued Feb. 28, 1993).

A. Concentrated market structure

The efficient exploitation of scale and scope economies could result in highly concentrated provider-network markets. Indeed, a recent report in The New England Journal of Medicine indicated that only 42% of the population lived in market areas capable of supporting managed competition with three efficient full-service provider networks. Moreover, 29% of the population lives in thinly populated market areas that could not support more than one efficient full-service provider network. The rest of the population lives in areas that can support limited competition with some sharing of hospital services.[20]

Concentrated markets generally are not good news for consumers. Problems with monopoly pricing are well understood. And many oligopolies have a penchant for price-fixing, market division, and other forms of collusion. These are issues that the antitrust authorities have always faced, although managed competition may provide some new twists.

The ability of health plans to collude requires agreement, as well as detection and punishment of deviation from a collusive agreement. This raises a number of issues. First, health care is a multiproduct industry, involving a large set of prices, though it might be possible for agreement to occur over a subset of these prices or on general levels of prices or market shares.

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[20]Richard Kronick, David C. Goodman, and John Wennberg, "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," 328 The New England Journal of Medicine 148 (Jan. 14, 1993).

For example, competitions for managed care contracts are generally in the form of across-the-board discounts off list prices, and collusion might therefore be over the size of the discount. Second, quality, an important dimension of health care competition, is difficult to define and sometimes to observe, although not always. For example, certificate of need (CON) applications for new equipment are publicly observable.

It is perhaps ironic that managed competition might further facilitate collusion by reducing price competition to a single capitation payment, by establishing a minimum standard of required services and by publishing a quality scorecard. These new features simplify consumers' problem of shopping for health plans and would thereby increase competition. On the other hand, they may also simplify a cartel's problem of monitoring defections from a collusive agreement.

Concentrated markets may be problematic even in the absence of collusive behavior. Oligopoly theory indicates that firms in concentrated markets sometimes can exercise unilateral market power.[21] This is true, for example, in markets for differentiated products, where a firm can raise its price and still retain customers who have a sufficient preference for that particular product.[22]

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[21]Horizontal Merger Guidelines (April 2, 1992).

[22]David Dranove, Mark Shanley and William White, "Price and Concentration in Hospital Markets," Journal of Law and Economics (April 1993), find evidence of market power in California hospital markets and find that hospitals with distinctive services have higher profit margins.

This point about product differentiation potentially applies to a market for health plans with different panels of providers. Consumers' preferences for particular doctors or for the proximity of a certain hospital could lead to a preference for one health plan over another. This being the case, members of a health plan oligopoly may find it irresistible to unilaterally raise premiums above the cost of providing care. Moreover, a market with fewer but larger health plans might result in less competitive pricing. If so, consumer welfare maximization may require weighing the economies of scale of more concentrated markets against a possible anticompetitive effect from the unilateral exercise of oligopoly power. Antitrust enforcers are accustomed to dealing with these types of problems.

Oligopoly may be particularly problematic with regard to bidding competition for large contracts.[23] The FTC's recently-filed Infant Formula cases provide a relevant example of possible anticompetitive concerns. In June 1992, the Commission accepted consent agreements with two leading manufacturers of infant

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[23]It is perhaps worth noting that effective competition may require excess capacity. This is most likely to be true in bid markets for large contracts, for without excess capacity in the market, and with long investment lags, it may be difficult in the short run for a buyer to switch to another supplier. A related problem may arise in markets where consumers choose between differentiated products, for without excess capacity in the market (or rivals' abilities to expand output quickly,) an individual firm might be able to brazenly raise price without fear of losing many customers to rivals. Both scenarios might apply to managed competition, depending on how it is organized. Thus, managed competition may face some conflicts between harnessing market forces to lower prices and achieving cost savings through the elimination of redundant capacity.

formula -- Mead Johnson and American Home Products -- and filed an action in federal court against a third -- Abbott Laboratories -- based on charges of collusion-facilitating practices and, concerning the action against Abbott, actual collusion. Although the cases are is still in administrative and court litigation and thus I cannot delve into all the facts, the complaint in federal court alleges that the $1.6 billion domestic infant formula industry is extremely concentrated, with the three defendants accounting for more than 90% of sales.

There are two portions of this case that are of particular relevance here -- both concern bidding by oligopolists for government contracts. The federal court complaint alleged that, during bidding to supply formula to the Department of Agriculture's Women, Infant and Children ("WIC") program in Puerto Rico, Abbott "conspired or combined with others to fix, stabilize, or otherwise manipulate" bids and to undermine cost containment efforts by "guaranteeing an open market system." An open market system allows all eligible manufacturers to supply formula to the WIC program in a particular state, while a sole source system selects a single supplier after soliciting sealed bids. Because open market systems are generally costlier for the government than sole source bidding, federal law creates a preference for a sole source award. The complaint alleged that Abbott provided information during the bidding process "with anticompetitive intent or without an independent legitimate business reason" that broadcast to competing bidders the

company's preference and intent to bid in such a way as to lead to an open market rather than sole source system in Puerto Rico. The three competitors in the Puerto Rico bids ultimately submitted only open market bids at the WIC auction, at significantly higher prices than they had bid at contemporaneous WIC bids in other jurisdictions.[24]

A complaint against Mead Johnson also contained an additional "price signaling" count relating to letters Mead sent to a number of states indicating the precise dollar amount it intended to offer in upcoming sealed bids for WIC contracts. The complaint alleged that the company "knew or should have known" that the information in the letters would become known to its competitors and that its competitors did become aware of the contents of the letters. As a result, the complaint alleged that uncertainty relating to Mead's bids was reduced and competition diminished.

In Infant Formula the government was clearly a large buyer, but this by itself did not prevent the alleged collusion. This experience suggests that the concentration of buying power through the HIPCs may not eliminate the potential for anticompetitive behavior. While such concentration on the demand side of the market possibly lessens, it is unlikely to eliminate

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[24]To the extent that managed competition involves competitively awarded contracts for some subgroups, e.g. Medicaid clients, a reduction in the number of bidders may lead to higher prices even if bidders do not act collusively. This general idea has considerable support in the economics literature on bidding, and can be relevant for merger policy.

completely concerns about anti-competitive behavior, leaving a role for antitrust enforcement. And, while some recent court decisions have recognized various forms of a "power buyer" defense to anticompetitive mergers,[25] because of the supposed ability of powerful buyers to break up collusion, the Infant Formula case suggests that the presence of large buyers alone may not eliminate the possibility of anticompetitive behavior.[26]

It is therefore worth considering the strategies available to a HIPC for constraining monopoly and oligopoly power. Some are more attractive than others, and several are assisted by the antitrust laws. One possibility is public ownership and control, perhaps along the lines of national health insurance in Canada or Great Britain. A second possibility is to regulate the market directly, although it is noteworthy that traditionally regulated industries, e.g. electric power and telecommunications, are moving toward more competition, and, consequently, increasing reliance on the antitrust laws for protection. Third, a HIPC might structure the market to trade off some economies of scale against the possible anticompetitive effect of a more concentrated market. Fourth, a HIPC might want to encourage

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[25]United States v. Baker Hughes, Inc. 908 F.2d 981,983 (D.C. Cir. 1990); United States v. Syufy Enterprises, 903 F.2d 659 (9th Cir. 1990); United States v. Archer-Daniels-Midland Co., 1991-2 Trade Cases (CCH) ¶ 69,647 (S.D. Iowa 1991); United States v. Country Lake Foods, 754 F. Supp. 669,675 (D. Minn. 1990).

[26]Mary Lou Steptoe, "The Power Buyer Defense in Merger Cases," 61 Antitrust Law Journal 493-504 (1993); Herbert Hovenkamp, "Mergers and Buyers," 77 Virginia Law Review 1369-83 (1991).

greater head to head competition by making health plans more alike.[27] Finally, a HIPC might rely on a threat of potential competition to discipline a monopolist and undermine oligopoly collusion. For this strategy to work, the threat must be credible, which depends on the height of barriers to entry. Consideration of entry conditions is of course standard practice for antitrust authorities. I would like to discuss barriers to entry in managed competition in a bit more detail.

B. Barriers to entry

If, as many observers expect, managed competition leads to integrated networks of health care providers that achieve various economies, successful entry into the market for health plans would most likely have to be on a large scale to be successful. Therefore, small-scale "toehold" entry simply would not achieve the economies of scale and scope required for effective competition. A new health plan must establish a large complex network of providers, either by acquiring or contracting with incumbent providers, or by introducing new providers into the market.[28]

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[27]This may be a reason to sacrifice some of the benefits to consumers of being able to choose from a variety of different types of health plans. Another reason noted in the managed competition literature is to avoid competition by "risk selection". Insurers can increase profits by designing their plans to attract relatively healthy patients, rather than by competing on price and quality.

[28]This may be less of a problem in unconcentrated urban markets. For example, a city like Chicago currently has dozens of health plans competing with each other. However, economies of scale may pose serious entry barriers in less concentrated markets.

Sunk costs also contribute to entry barriers. A new large-scale entrant cannot necessarily expect that less efficient competitors will exit quietly. The prospect of aggressive competition with large competitors committed to the market makes entry less attractive.

Along these lines, it is possible that managed competition may encourage a trend to exclusive dealing contracts that link physicians and other providers to a single network. To be sure, exclusive dealing can have efficiencies. For example, such contracts can guarantee the steady supply of services and thus assist in better long-range planning. And it is probably inefficient for more than one utilization review organization to oversee the same physician. Finally, an exclusive deal would eliminate problems of physicians having any incentive to shift their patients from one plan to another.

Whether or not there is an efficiency motive, however, exclusive deals are potentially a barrier to entry. If all providers are already "signed up" with incumbent health care networks, it will be difficult to establish a rival network. A new entrant would have to "bid" participating physicians away from exclusive deals with incumbents, and this could be very expensive. Individual physicians could take a "you first" attitude, reluctant to sacrifice a beneficial exclusive deal unless a sufficient number of other physicians have already signed up with a new plan to make it viable. For this reason, a new entrant might have to pay a significant premium to gain a

critical mass of participating physicians. Thus, by raising the costs to new entrants by exclusive dealing, incumbent oligopolists might successfully maintain their market power.[29]

Limitations on entry affect not only price and quality of services, but also variety of services offered. Obviously a standardized benefits package reduces the scope for product variety, but it is still possible to deliver the same package of benefits in different ways. These organizational differences may have cost consequences and may matter to consumers directly. In principle, a single firm could offer its customers a menu of different types of health plans. For example, Blue Cross does this. So oligopolists could compete over the variety of their menus. However, it might be difficult under managed competition for an integrated network to treat different patients in different ways. Moreover, experience has shown that new entry is an important source of organizational innovation. Thus, low entry barriers may be very important for an innovative market place.

V. Antitrust challenges for the future

A. Merger policy

In the health care area, merger policy has been directed mostly at hospitals. In a managed competition environment attention may be redirected to provider networks. It is possible

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[29]See Steven Salop and David Scheffman, "Raising Rivals' Costs," 73 American Economic Review 267-71 (1983); Eric Rasmussen, J. Mark Ramseyer and John Wiley, "Naked Exclusion," 81 American Economic Review 1137-45 (1991).

that geographic market definition may be different, depending on market boundaries defined by HIPCs.[30] Product market definition could be affected as well.[31]

Efficiencies analysis will require assessments of economies of scope and scale, including network economies. This will be difficult. However, the cost characteristics of a large integrated HMO like Kaiser Permanente in California may provide a useful benchmark for comparison as is suggested by the New England Journal of Medicine report I mentioned before.

B. Exclusive dealing

Integrated provider networks feature both horizontal and vertical restraints that potentially come under scrutiny by the antitrust laws. On this topic, I would like to focus somewhat narrowly on issues surrounding exclusive dealing. These issues may be particularly challenging in a managed care environment.

As the recent decision concerning a healthcare exclusive contract in U.S. Healthcare Inc. v. Healthsource, Inc. shows,[32] courts for the most part analyze exclusive dealing contracts under a "rule of reason" rubric -- that is, a full analysis of

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[30]This raises interesting questions about appropriate market definition. What is the right size for a HIPC? Larger market areas may better exploit economies of scale, but may also have consequences for actual and potential competition by encouraging greater consolidation of assets.

[31]For example, market definitions may reflect managed competition's emphasis on bidding for all healthcare services based on a single capitated payment.

[32][Current Binder] Trade Cases (CCH) ¶ 70,142 at 69,587 (1st Cir. Feb. 26, 1993).

the facts with a careful weighing of the competitive benefits and dangers of such contracts.[33] As I noted before, exclusive dealing contracts can have efficiencies. But there is at least one possible danger for competition recognized by antitrust laws: an exclusive arrangement may "foreclose" so much of the available supply of services that current competitors or new entrants may be limited or excluded.

The precise contours of the legal standard for whether an exclusive arrangement has foreclosed so much of the market as to be anticompetitive has been the source of ongoing development in FTC and court case law.[34] In an advisory opinion issued to Burnham Hospital in 1983 concerning an exclusive services contract with radiologists, the Commission outlined the relevant factors in this determination: (1) the proportions of the local hospital and physician services markets involved in the contract; (2) the purposes of the contract; (3) its duration; (4) the extent to which it deters new entry by physicians or other providers into the market; (5) the benefits that the hospital and the public derive from it; and (6) the extent to which physicians compete with each other for the contract.[35]

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[33]Tampa Electric Co. v. Nashville Coal Co., 365 U.S. 320 (1961); Standard Oil of California v. United States, 337 U.S. 293 (1949) (Standard Stations).

[34]See generally, ABA Antitrust Section, Antitrust Law Developments 170-79 (3d Ed. 1992) (collecting and discussing cases).

[35]Letter to Robert Nord, Counsel, Burnham Hospital, 101 F.T.C. 991 (Feb. 24, 1983).

In advising that the exclusive contract for radiologists did not violate the antitrust laws, the Commission noted that Burnham Hospital had a 26% share of the market, that radiology services were available outside the hospitals from independent radiology laboratories, that the three-year contract was of reasonable length, and that either party could terminate the contract on short notice, so that potential for future competition for the contract was preserved.

By contrast, in Oltz v. St. Peter's Community Hospital,[36] the Ninth Circuit found that an exclusive contract for anesthesia services had an anticompetitive effect where the hospital was the only effective source of anesthesia services in the market.[37] This possibility of an anticompetitive effect from market foreclosure has been recognized by federal antitrust enforcement agencies. In 1984, the Department of Justice announced plans to challenge a preferred provider organization (PPO) that, DOJ alleged, sought to restrain competition by enrolling nearly 90% of physicians in one market and 50% of physicians in another market as members and forbidding them from contracting with other

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[36]861 F.2d 1440, 1446-49 (9th Cir. 1988).

[37]The court in Oltz stressed, however, that the exclusive contract may have been the result of a conspiracy between the hospital and anesthesiologists to exclude competition. Consequently, in response to the hospital's argument that a finding of liability would preclude any rural hospital from entering into exclusive contracts, the court noted that this conspiracy element meant that its decision "cannot be read as establishing any rule applicable to other situations involving rural hospitals engaged in exclusive contacts for staff privileges." Id. at 1449.

PPOs or health care delivery systems.[38] Another source of antitrust concern would be if the contract seemed excessively long, and therefore insulated the incumbent from competition for a long period of time.[39]

In the Healthsource case I noted earlier, the court considered the case of an HMO (Healthsource) that offered its physicians higher capitation payments in exchange for the physicians' agreement not to participate in any other HMO. The Court found insufficient proof of substantial market foreclosure to warrant scrutiny under Tampa Electric's rule-of-reason approach to exclusive dealing. Even though as much as 25% of New Hampshire physicians were tied to Healthsource, Judge Boudin, the author of the opinion, reasoned that an entrant might still be able to contract with the other 75%. Moreover, since Healthsource's exclusivity clause could be cancelled with 30 days notice, Judge Boudin noted, it might not be too expensive for a rival to attract physicians who had a small caseload with Healthsource. Judge Boudin was careful, however, to stress that

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[38]Stanislaus Preferred Provider Organization, Inc., Dept. of Justice Press Release (Oct. 12, 1984) (no lawsuit was filed because, the press release noted, the organization had decided to dissolve itself).

[39]Of course, to the extent that the exclusive contract "locks in" a group of specialist providers with market power, a hospital that conditioned purchases of those specialty services on purchases of other hospital services could find its practices challenged as an illegal "tie-in" under the antitrust laws. See, e.g., Lancaster Community Hospital, 940 F.2d 397 (9th Cir. 1991), cert. denied, 60 U.S.L.W. 3578 (1992) (hospital accused of tying HMO's purchase of ob-gyn services to purchase of other inpatient services.)

the plaintiff in that case had refused to provide any evidence in support of a rule of reason case, since the plaintiff there was apparently resting its case on allegations of per se unlawful activity, which the court had earlier rejected. Consequently, it is unclear how the court would have treated the matter if further evidence had been presented.

The market foreclosure issue may become more prominent in a managed competition environment if providers become more integrated. For example, markets might be arguably foreclosed through a combination of healthcare exclusive dealing arrangements. Hypothesize that under a future managed competition regime New Hampshire has four rival health plans, each organized as IPA-model HMOs, and each binding 25% of New Hampshire physicians with an exclusivity clause like Healthsource's. Further hypothesize a potential entrant into New Hampshire that has devised a radically innovative health plan that has been successful in other markets. To succeed in New Hampshire the entrant would have to compensate physicians to cancel their exclusivity clauses with incumbent plans. The total amount of compensation required to attract a sufficient number of physicians could be a prohibitive barrier to entry.

VI. Conclusion

Antitrust enforcement is a proven policy tool for promoting competition. Its purpose is to maintain a market structure where competition works well and to prevent conduct that undermines competition. Certainly, antitrust policy is not the only

approach to improving the efficiency of markets. In some circumstances, such as where economies of scale and scope require a highly concentrated market structure, direct regulation might be justified.[40] However, to the extent that antitrust laws help secure a competitive marketplace, less direct regulation may be necessary.

It may be that significant economies are to be achieved by a more integrated and consolidated health care marketplace. Time will tell. However, I think it important during the transition to a new market structure to carefully weigh economic efficiencies against possible harm to competition. This is what antitrust policy, and particularly merger policy, is designed to do. The FTC's experience with hospital and other mergers is that the assets of merged firms are difficult to unscramble *ex post*. If nothing else, antitrust policy can help avoid a potentially

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[40]Of course, any direct price regulation of health care services must be carefully tailored to ensure that providers, who may have market power in a particular market, cannot effectively tie non-regulated services to regulated services in order to circumvent any price regulation. For example, in the matter of Gerald S. Friedman M.D., 55 Fed. Reg. 27,686 (July 5, 1990), the FTC settled complaint charges that Dr. Friedman had engaged in an illegal tying arrangement, requiring physicians who used his out-patient dialysis services to use his in-patient dialysis services when their patients were hospitalized. The complaint alleged that Dr. Friedman had market power in out-patient services but could not exploit it because Medicare (the dominant purchaser of chronic dialysis services) limits the amount of reimbursement available for out-patient services. Medicare does not, however, regulate reimbursement for in-patient dialysis. Consequently, the complaint alleged that Dr. Friedman used the tying arrangement to circumvent Medicare's price regulation and charge higher than competitive prices for the tied in-patient services.

excessive consolidation of the industry by requiring a careful weighing of the merits.

At the same time, antitrust policy makers will have to recognize both new efficiencies and new potential for anticompetitive conduct in a managed competition environment. Merger, exclusive dealing, and other antitrust policies must adapt appropriately.

The precepts of managed competition have great promise for containing health care costs and providing access to the tens of millions currently uninsured. This promise may not be fully fulfilled, however, without a complementary antitrust policy that will ensure the type of competition that will work to benefit consumers.