Federal Trade Commission

ANTICOMPETITIVE CONCERNS RELATING TO INFORMATION SHARING IN HEALTH CARE MARKETS

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I. INTRODUCTION

It is a pleasure to be here today to discuss information exchanges in the health care context. The focus of my talk is the collection and dissemination of market data among competitors in health care markets. I will begin my discussion with the current status of the law on information exchanges and the relevant inquiries necessary to determine if an information exchange causes competitive harm. Then, I will turn to the nature of competition in health care markets and possible areas of anticompetitive information exchanges. I will end with a discussion of what is expected to occur in those markets as a result of the emerging health care reform, as well as what I see as potential antitrust concerns.

II. CURRENT LAW

Information exchanged among competitors can have legitimate -- procompetitive -- purposes that ultimately benefit consumers, illegitimate -- anticompetitive -- purposes that facilitate collusion, or both. Legitimate exchanges of information allow businesses to plan efficiently and compete effectively with the resulting savings being passed on to consumers in the form of lower prices. Illegitimate exchanges threaten competition because they reduce the uncertainty in markets which can make it easier for competitors to coordinate pricing and restrict output. To determine whether an information exchange will be harmful to competition, and therefore subject to antitrust scrutiny, several

factors must be examined. Those factors include: the competitive position of the parties exchanging the information and the degree of competition in the markets within which they compete; the competitive significance of information exchanged; and whether the exchange serves a legitimate business purpose.

Information exchanges between firms that currently are not and do not intend to become competitors raise minimal antitrust risk, unless one or more of the parties are conduits of information to a competitor. If the exchanging parties are competitors, then the structure of the market in which they compete needs to be examined.[2]

A facilitating practice such as information sharing is more likely to occur in markets that are susceptible to collusion, but in which competitors face obstacles to collusion.[3] For example, if competitors in a market have significantly different delivery costs, then making delivered pricing formulas available can overcome this obstacle to collusion.

Market structure is important to analyze to determine whether market conditions are conducive to collusion. The Merger

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[2] See United States v. Gypsum, 438 U.S. 422, 441 n.16 (1978); United States v. U.S. Container Corp., 393 U.S. 333 (1969).

[3] See generally Remarks of Mary Lou Steptoe, Acting Director, Bureau of Competition, Federal Trade Commission, before the American Bar Association (August 9, 1993).

Guidelines suggest that collusion "may be facilitated by product or firm homogeneity and by existing practices among firms, practices not necessarily themselves antitrust violations, such as standardization of pricing or product variables on which firms could compete. Key information about rival firms and the market may also facilitate reaching terms of coordination."[4] As Department of Justice Antitrust Enforcement Guidelines for International Operations note:

> If the parties to an information exchange collectively do not possess market power, or if the relevant market or markets are not concentrated or are subject to easy entry, then an exchange of information by itself would not likely harm competition. On the other hand, if the market is highly concentrated and the parties account for most or all of the sales in that market, then an exchange of competitively sensitive information among them might be anticompetitive.[5]

The next area of inquiry is what type of information is being exchanged. The courts have long held that the exchange of price information among buyers and sellers can be some of the most dangerous information to exchange from an antitrust perspective. Sharing price information can lead to allegations of horizontal price fixing which the courts have held to be per

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[4] Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (April 2, 1992) § 2.11 (emphasis added), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,104.

[5] U.S. Department of Justice, Antitrust Division, Antitrust Guidelines for International Operations (1988), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,109 at 20,589.

se illegal.[6] More generally, if an exchange is frequent and timely, it is considered more dangerous from an antitrust perspective, because such information will be more valuable for coordinating pricing actions or for detecting cheating by members of a cartel. Information that is both historical and, in most cases, available to the general public poses the least antitrust concern. Publically available information can have a procompetitive effect because buyers can more easily evaluate sellers' prices, and collusion can be more easily detected -- not only by market participants, but also by antitrust enforcement agencies.

Information exchanges that affect price **indirectly** may also give rise to an inference of illegal coordination of price, especially if the effect of the agreement is to stabilize prices or reduce price competition. Although such exchanges may not be considered per se illegal, the courts in both United States v. Container Corp. and United States v. U.S. Gypsum Co. assert that the exchange of price information in a concentrated market by

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[6] See e.g., Mandeville Island Farms v. American Crystal Sugar Co., 334 U.S. 219 (1948) (buyer price fixing unlawful); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) (agreement among competing sellers to stabilize prices by purchasing excess supply held per se unlawful); United States v. Trenton Potteries Co., 273 U.S. 392 (1927) (price fixing among sellers held per se unlawful regardless of reasonableness of the price fixed).

producers of a fungible product can be unlawful under a rule of reason analysis.[7]

Additionally, the exchange of cost-related information rather than price can raise antitrust concerns, especially when accompanied by an explicit or implicit purpose of intent to restrain competition.[8] **In two recent cases, the Department of Justice negotiated consent agreements dealing with cost information. The most recent occurred in Utah, where the hospitals in the area had been exchanging nurse wage information**

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[7] United States v. United States Gypsum Co., 438 U.S. 422, 446 (1978) ("Exchanges of current price information, of course, have the greatest potential for generating anticompetitive effects and although not per se unlawful have consistently been held to violate the Sherman Act."); United States v. Container Corp., 393 U.S. 333, 335 (1969) (exchange of historical price information in highly concentrated market violated section 1 as there was an inference that the exchange had an anticompetitive effect on price).

[8] Compare Maple Flooring Manufacturers' Ass'n v. United States, 268 U.S. 563, 585-86 (1924) (absent evidence of agreement or concerted action to restrain competition, dissemination of current production cost information among producers responsible for a majority of market production does not lead to inference or conclusion of antitrust violations; information was also make available to the public, i.e., buyers through trade journals) with American Column & Lumber Co. v. United States, 257 U.S. 377, 411 (1921) (plan by which information on market conditions was analyzed, compiled and exchanged only among competition producers violated antitrust laws even absent explicit agreement; reports were circulated accompanied by analysis and recommendations regarding future industry-wide action, and the plan generally advocated cooperative rather than competitive action).

over several years. The consent prohibits such exchanges.[9] The other recent action involves a consent agreement which prohibits nursing home owners from exchanging information about nurse registries for five years.[10]

An information exchange may be subject to antitrust scrutiny absent an outright agreement.[11] Courts have inferred a price-fixing conspiracy from evidence of parallel pricing in an oligopolistic setting.[12] For example, the district court in In re Coordinated Proceedings in Petroleum Products Antitrust Litig.,[13] denied summary judgment to defendant oil companies. The court found sufficient evidence to support an inference of

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[9] United States v. Utah Soc'y for Healthcare Human Resources Admin., No.____ (D. Utah Mar. 14, 1994) (stipulated final judgement); State of Utah v. University of Utah, No. ___ (Utah 3rd Dist. Ct. Mar. 14, 1994).

[10] See In re Debes, 57 Fed. Reg. 39,025 (Aug. 28, 1992).

[11] 101 F.T.C. 425 (1983), vacated sub nom. E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

[12] The Department of Justice recently settled a matter in which it alleged that eight airlines unreasonable restrained price competition in the $40 billion domestic air travel industry through a computerized fare exchange system -- the Airline Tariff Publishing Co. ("ATP"). The complaint alleged, among other things, that defendants' agreement to maintain, operate and participate in the ATP system was an unreasonable restraint of trade. Specifically, it alleges that certain aspects of the ATP fare dissemination system facilitated coordination of fare increases and eliminated discounts. The settlement eliminated the mechanism through which the alleged information was exchanged. See United States v. Airline Tariff Publishing Co., Civ. No. 92-2584 (D.D.C. March 17, 1994).

[13] 906 F.2d 432 (9th Cir. 1990), cert. denied 111 S.Ct. 2274 (1991).

conspiracy where current and prospective price information was allegedly shared through press releases, price postings, and direct contacts among competitors. Ultimately, the parties settled this matter out of court.

The Second Circuit decision in Ethyl Corp. provides some guidance for approaching the analysis of an information sharing mechanism absent an explicit agreement. The business practices in question in Ethyl included a contractual obligation of four manufacturers of antiknock compounds to give their customers at least 30 days advance notice of price increases and an agreement to give advance notice of price increases to the press. The Commission found that these practices, which the manufacturers had unilaterally adopted, reduced some of the uncertainties that firms would have faced regarding their rivals' pricing strategies, and facilitated parallel pricing at levels higher than might have prevailed in a competitive market. The structural factors included a market prone to collusion based on high concentration and barriers to entry, and evidence of noncompetitive market performance.

Although the Second Circuit reversed the finding of liability based on failure to meet the "substantial evidence" test, it concluded that to establish a law violation in this context, "absent a tacit agreement, at least some indicia of oppressiveness must exist such as (1) evidence of anticompetitive

intent or purpose on the part of the producer charged, or (2) the absence of an independent business reason for its conduct." [14]

Determining whether there is a legitimate "independent business reason" for the information exchange is the final area of inquiry.[15] The existence of a procompetitive purpose increases the likelihood that an information exchange will not pose an antitrust risk. Conversely, the existence of an anticompetitive purpose increases the likelihood that an exchange of price information will be held unlawful.[16] The FTC and DOJ have provided guidance in this area. A few years ago, the FTC stated that it would not challenge the collection and dissemination of dentists fees where the likely effect was to aid consumers in evaluating the dentists' fees and the level of benefits paid by their insurance plans.[17] In particular, FTC

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[14] 729 F.2d at 139. The Commission recently brought a similar case against participants in the infant formula industry. Two of the parties -- Mead, Johnson and American Home Products -- entered into consent agreements. The case against Abbott Laboratories is currently pending before a federal district court. See FTC v. Abbott Laboratories, No. 92-0038 (D.D.C. June 11, 1992); FTC v. Mead, Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent agreement); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992) (consent agreement); Abbott Laboratories, Dkt. No. 9253 (Feb. 4, 1994) (final order).

[15] See generally Dennis A. Yao and Susan S. DeSanti, "Game Theory and the Legal Analysis of Tacit Collusion," The Antitrust Bulletin (Spring 1993).

[16] See Sugar Institute v. United States, 297 U.S. 570, 599-601 (1936); American Column & Lumber Co. v. U.S., 257 U.S. 377, 411-12 (1921).

[17] Letter from Timothy Muris to Peter Sfikas (Aug. 26, 1985).

staff stated that the fact that the information disclosed would be made available to patients and insurers, not to dentists; the fact that ranges of prices, not specific prices, would be disclosed; and that the dental service markets are usually not concentrated made it unlikely that the proposed information sharing would facilitate collusion. DOJ issued a Business Review Letter to the Stark County Health Care Coalition, Inc. (Aug. 30, 1985) indicated it would not challenge the collection of health care utilization and cost data by employers because the purpose was to facilitate more informed purchasing decisions and competition. Additionally, DOJ stated that the structure of information collection would not facilitate collusion.

III. INFORMATION IN HEALTH CARE MARKETS

Before turning to the current health care reform proposals, I will review some of the more traditional problems associated with information sharing in the health care industry. These issues are not unique to health care markets, although some of the features of health care raise these issues in a particularly interesting and challenging way.

The basic antitrust concern with information sharing in health care markets, as in other markets, is whether the information exchange's anticompetitive risks are sufficiently outweighed by the potential for procompetitive efficiencies.

There may, of course, be instances in which an anticompetitive purpose is the prime reason for the information exchange. However, most cases probably involve legitimate attempts to increase efficiencies; the problem is that many of these legitimate attempts may (directly or indirectly) involve significant anticompetitive elements as well. Enforcement agencies are careful to consider the potential efficiencies associated with various inter-organizational relationships and with information sharing.

As I discussed previously, the starting point for analyzing information exchanges is determining the relationship of the exchanging parties, and the degree of competition in the market. In the health care context, the analysis of these issues is not unique. As with other markets, the level of concentration and geographic markets can be difficult to determine in the health care context. For example, many hospital markets are highly concentrated because travel distance to the hospital is one of the most important determinants of where a patient goes for hospital care. Additionally, concentration can be an issue for physicians, especially when dealing with specialists in a small geographic area.

The second factor I mentioned -- the competitive significance of the information exchanged -- raises especially interesting issues in health care markets. For example, although

many types of hospitalizations are relatively rare or infrequent, many medical problems requiring a hospital stay are common and occur with relatively high frequency and predictability. Does this characteristic of hospital demand lessen the information needed to enforce a cartel agreement? In other words, can providers detect "secret price cuts" simply by observing volume changes in selected "high frequency" hospitalizations?

Additionally, many believe that quality competition is an important characteristic of health care markets, especially where prices are regulated such as with Medicare. Could this imply that the sharing of cost information (and therefore, information about quality investments in facilities, equipment, and personnel) is potentially more problematic in health care than it might be in other industries? On the other hand, many states, for example, have Certificate of Need laws and regulations which must be satisfied before new facilities may be built. These state-imposed requirements make competitive actions and investments more visible.

When approaching these questions, it is important to understand some of the more salient features of health care markets that differentiate them from many other markets. First, there is imperfect information -- consumers are not fully

informed.[18] Sick patients often are not in a position to review the appropriateness or necessity of care. Moreover, they generally do not know what therapy is necessary, and as a result, physicians may be able to prescribe more services than are necessary in an attempt to increase their income. Information exchanges would not appear to be directly affected by this feature of the market. Nonetheless, the ability to exchange certain types of information can be useful for creating efficient contracts between non-integrated providers, and may have some general value for "benchmarking" more efficient practices.

Second, there is widespread insurance -- most consumers are insured. Insured consumers do not bear the full cost of their decisions and have little incentive to weigh the costs and benefits of treatment. However, many insurers are imposing greater copayments on consumers in an effort to make patients more sensitive to price. For this reason, the rise in the availability of public price information may become increasingly more important as consumers are made more aware of price, and as managed care and capitation become more prevalent.

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

Third, it is generally recognized that output in the health care industry is difficult to measure. Medical benefits can take many forms, from a cure to a reduction of pain. More importantly, there are few studies that try to assess the cost effectiveness and efficacy of alternative forms of medical treatment. Many identify the inappropriate use of medical resources as one source of inefficiency in the industry. Thus, it would appear that the exchange of information between hospitals and physicians related to the efficacy of various treatment methods would be valuable.

These features create numerous incentive problems for physicians and patients that make cost containment difficult. The incentive problems have been addressed with varying degrees of success by using strategies involving, for example, vertical integration and risk-sharing (so physician incentives are improved), incentive contracting, and utilization reviews. These strategies can be implemented more easily in an environment where more and better information is available.

Another antitrust issue is collaborative efforts by physicians. Many physicians and physician groups have argued for permitting individual physicians to discuss price together as prelude to negotiating with insurance providers.[19] Their

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[19] See letter from Joseph Painter, M.D., Chairman, Board of Trustees, American Medical Association to Janet D. Steiger, Chairman, Federal Trade Commission (Apr. 30, 1992).

rationale is that such discussions promote competition by reducing the search costs for the health plan and could involve promotion of a new product, such as area-wide coverage.[20] However, absent some form of economic integration, such price discussions are per se illegal.[21] Integrated parties' collaboration is not (absent market power) condemned, in order to preserve procompetitive integrative efficiencies such as scale economies, combining of complementary resources, and facilitating innovation.

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[20] Physicians also agree that collective negotiations are necessary to balance the alleged market power of payors. At least two other arguments have been made on this issue. First, some have argued that it is necessary for non-integrated physicians to band together to offset buyers (alliances, health plans, etc.) possessing market power. Second, some argue that restricting information slows down the transition between the current health care system and a more efficient health care system. While these may be valid concerns, it appears that they may only be different in degree from concerns about the efficiency of information sharing in other markets. Additionally, if the buyers do possess market power, then enabling the physicians to gain such market power might only result in creating a bilateral monopoly which has minimal procompetitive efficiencies.

[21] The Supreme Court in Arizona v. Maricopa Medical Society, 457 U.S. 332, 356-57 (1982) characterized an maximum fee schedule established by providers naked price fixing without integrative efficiencies: "The foundations are not analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and hare the risks of loss as well as the opportunities for profit . . . . [T]he fee arrangements . . . in this case are among independent competing entrepreneurs." See also United States v. Burgstiner, 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D. Ga. 1991) (consent decree) (obstetricians in Savannah, Georgia, exchanged information about their fees for deliveries, which allegedly resulted in a significant price increase for deliveries in the area.).

In what appears to be an effort to avoid the problem of non-integration, providers use associations and third-party purchasers as vehicles for information sharing. For example, associations can initiate a data collection project that might benefit its members. The antitrust analysis of information sharing is the same, whether or not it is achieved through an association. Such arrangements might still be considered per se illegal under Maricopa, unless precautions are undertaken to insure that the competitively sensitive information is not directly shared among competitors.

Both FTC and DOJ have also expressed concerns about proposed activities by associations that had potential to facilitate price or quality collusion. For example, in a FTC Staff Letter to American Society of Internal Medicine (Apr. 19, 1985), staff expressed concern over the Society's proposed development and dissemination of relative value guides (RVG) which would list medical services by descriptive codes and the Society would assign a value to each service based on cost, time, complexity and level of training required. Staff was concerned that adoption and dissemination of RVG's could facilitate agreement by physicians to adhere to the RVG's in determining charges for their services.[22]

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[22] The same is true with attempted boycotts by associations. In a recent FTC case, the Commission entered a consent agreement with the Maryland Pharmacists Association and the Baltimore Metropolitan Pharmaceutical Association, involving (continued...)

In a non-health setting, but with implications for health professionals, the Department of Justice issued a business review letter which stated that a bar association's survey of members' general hourly billing rates and fees "could be used as vehicle by Association members to agree explicitly or implicitly on various fees or billing rates . . . ." The letter also expressed concern that the association did not appear to have plans to implement sufficient procedural safeguards to ensure that the fee data is appropriately protected.[23]

Some preferred provider organizations ("PPO") and health maintenance organizations ("HMO") are created through the use of a "messenger" approach which determines reimbursement levels and contract terms. The "messenger" model involves the use of a third-party agent acting as an intermediary between the purchasers or payers and the (future) PPO's or HMO's providers. The agent transmits price and cost information on an individual

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[22](...continued)
allegations of a conspiracy to boycott the prescription-drug plan for Baltimore city government employees in order to force the plan to increase its reimbursement rate for prescriptions. The FTC alleged that, through meetings and exchanges of information among their members, the two associations participated in an illegal agreement to refuse to participate in the plan at a reduced reimbursement level. The consent order prohibits meetings of pharmacy representatives at which statements would be made concerning intentions to enter or refuse to enter any third-party payor prescriptions drug plan. See Maryland Pharmacists Association and the Baltimore Metropolitan Pharmaceutical Association, FTC Dkt. No. 9262 (March 1, 1994) (consent order).

[23] See DOJ Business Review Letter to South Suburban Bar Association (Nov. 15, 1993)

or aggregated basis to purchasers or payors, receives the purchasers' or payers' offer, and transmits the acceptance or decline of services back to the PPO or HMO and its providers. If the offer is accepted, then a contract is entered between the PPO and the purchaser or payor, with those providers who accepted the offer participating in servicing subscribers under the contract.[24]

The "messenger" approach helps prevent providers from sharing the information among themselves and collectively agreeing on a price. This approach appears to avoid the per se standard of review because the third-party agent receives the price information from each provider and each provider decides independently whether or not to accept the price. Under the rule of reason standard, this type of arrangement seems to produce some efficiencies by reducing the transactions costs through the use of standard contract terms.

Where conditions are unlikely to lead to collusion and some legitimate efficiency can be identified, the agencies have indicated they are unlikely to take action. For example, the Department of Justice recently issued a Business Review Letter to Houston Health Care Coalition (March 23, 1994), stating that it would not challenge as anticompetitive a proposal by the

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[24] See generally American Bar Association, Section of Antitrust Law, Managed Care and Antitrust: The PPO Experience (1990).

Coalition to form a group purchasing association that will contract with health care providers for delivery of health care services to the employees and dependents of the association's members at predetermined reimbursement amounts. The association plans on developing a schedule of reimbursement rates which will be distributed to area providers so they may decide to contract with the association. The DOJ review letter points out that the association plans on using a third party to collect historical cost data from area providers, with no provider having access to the data submitted by another provider. The letter also points out that the Coalition represented that, "in general, no more than 20 percent of any health care specialist-physician providers in any relevant market in which the association operated will be associate members." The one exception to this threshold is for providers that are the sole providers of the specialty in the relevant market.[25]

More generally, the Federal Trade Commission and the Department of Justice have recently provided some guidance on information sharing as part of the six enforcement policy statements regarding the Health Care area that were jointly issued by the agencies last September.[26] The Health Care Policy

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[25] Letter at 2.

[26] U. S. Department of Justice, Antitrust Division, and Federal Trade Commission, Statements of Antitrust Enforcement Policy in the Health Care Area (Sept. 15, 1993) ["Health Care Antitrust Policy Statements"].

Statements set forth antitrust "safety zones" that do not change the law or current enforcement policy, but clarify and confirm existing policy in a definitive way. They describe specific, objective conditions under which the federal agencies will not, absent (rare) extraordinary circumstances, challenge various types of joint activities among health care providers.

One statement deals directly with exchanges of price and cost information among hospitals. The statement observes that the two enforcement agencies "will not challenge, absent extraordinary circumstances, hospital participation in written surveys of (a) prices for hospital services, or (b) wages, salaries or benefits of hospital personnel," if certain conditions are met: broadly, the survey must be managed by a third party, the data must be more than 3 months old, and criteria for number and relative size of firms surveyed must sufficiently aggregated to make the data for any one hospital indistinguishable. The statement warns that exchanges of information as to planned prices or wages are likely to be considered anticompetitive. This incorporates the understanding that historical data collection by a neutral third party in most cases does not pose significant antitrust risks.[27]

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[27] Recently, there has been a movement in the business community toward more cooperative strategies. For example, companies are sharing information through benchmarking activities in an effort to learn about others operations. If the participants are competitors, antitrust risk is minimized if there is a lack of market power, as well as safeguards against the costs of the participants being identifiable.

IV. INFORMATION EXCHANGE AND MANAGED COMPETITION

The federal health care reform plans under consideration introduce a number of changes that will directly and indirectly affect the structure and performance of the health care markets in the United States and impact antitrust policy with respect to information sharing.[28] I will now give a quick summary of the changes contemplated in the federal health care reform plans and then speculate briefly on information exchange issues--some new, some old-- that may become prominent as a result of managed competition style health care reform.

The Clinton Administration and various members of Congress have proposed legislation that would change our current health care markets in an attempt to provide broader coverage and reduce costs.[29] The majority of these proposals incorporate various forms of what has become known as managed competition, which involves competition among health plans on the basis of price and quality. Most proposals call for the establishment of some sort of governmental or quasi-governmental body that would contract for health plans on behalf of consumers. These alliances would

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[28] Many of these changes have already been enacted in various forms in state legislation.

[29] The various plans introduced include White House Domestic Policy Council, Health Security: The President's Report to the American People (1993); H.R.1200, 103rd Cong., 1st Sess. (March 3, 1993) (introduced by Rep. McDermott); H.R. 3222, 103 Cong., 1st Sess. (Oct. 6, 1993) (introduced by Rep. Cooper); H.R. 3080, 103rd Cong., 1st Sess. (Sept. 15, 1993) (introduced by Rep. Michel); S. 1770, 103 Cong. 1st Sess. (Nov. 22, 1993) (introduced by Sen. Chafee).

offer consumers several pre-negotiated health insurance packages that would vary on price and quality. They will also provide consumers with comparison reports that evaluate each of the competing health plans.

The purpose behind the alliances appears to be to encourage the formation of networks of large vertically and horizontally integrated health plans and providers. The health plans will be encouraged to broaden the services they offer, including the level of care and administrative services covered. For example, a health plan would contract with provider networks for services (such as primary and secondary care, specialty care and hospitalization) and would include an insurance company that provides quality control, financial administration and utilization review. The idea is to create efficient full-service health organizations to provide high quality, low cost health care to consumers.

Provider networks would be paid on a fixed annual per capita basis to provide all health care services for its clients. A network might include diagnostic facilities, laboratories, nursing homes, and other providers. Most of these networks will either be fully integrated, like Kaiser Permanente, or partially integrated, meaning that they are created by a series of contractual arrangements. The expected efficiencies from these arrangements include economies of shared services, coordination

economies, and improved organizational incentives for the delivery of cost-effective care. The hope is that consumers will benefit from the efficiencies derived from these networks in the form of better quality care at lower costs.

The expectation of most managed care-oriented reformers is that considerable consolidation of the health care system will occur and lead to more efficient provision of health care. Such consolidation implies that collusion may become easier in many markets, and, therefore, that information exchanges that might facilitate collusion might become more likely. Of course, in order to have a collaborative system of health plans and providers, a certain degree of information needs to be exchanged. The areas of potential concerns are with the information that health plans provide to the alliances and its dissemination, as well as the information that provider networks share in their formation and negotiations with health plans. As discussed before, key issues are the efficiency aspects and the potential anticompetitive aspects of an information exchange.

Under the current proposals, the alliances are expected to present a uniform basic health plan, as well as a variety of other plans, at defined prices. This could have competitive consequences. For example, if the alliances and health plans contract to provide a uniform package of benefits to consumers with specified prices and those contracts are made public, then

price information is available which could facilitate coordination among competitors. Such risks could be avoided by allowing differentiation among plans, such as allowing the plans to offer more than just government-prescribed benefit packages through the alliances.[30] Another way of avoiding anticompetitive harm is to ensure that there is interplan competition. If only a few plans are allowed to dominate, then the plan offerors might have the market power to raise prices, undertake exclusionary practices, or raise barriers to entry.

Information exchanges involved in the creation and implementation of large provider networks is another area of potential anticompetitive concern. There are at least two kinds of potential problems flowing from legitimate efficiency-enhancing business transactions. First, information must be exchanged in order to determine if a potential alliance makes sense in terms of fit and, later, in terms of a reasonable contractual relationship. This problem, of course, is not special to the health care market but is endemic to any proposed combination or venture. Second, many combinations may occur between horizontal competitors by necessity (e.g., there is only one obstetrics unit in a geographic market that affiliates with two or more potential provider networks), and could involve "spillover" information problems.

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[30] See Robert E. Block and Donald M. Falk "Antitrust, Competition, and Health Care Reform" Health Affairs 212 (Spring II 1994).

Consider for a moment a partially integrated network -- one created through contractual arrangements between physicians, hospitals, and other providers. A collaboration on price by an integrated risk-sharing network is not considered per se illegal. However, if groups of providers contract non-exclusively to form a network and they jointly offer prices there could be a spill-over effect where the information used legitimately to serve one function will be used to facilitate collusion in other areas.[31] The American Hospital Association and others have argued that general information exchanges about costs, etc. are beneficial for hospitals to facilitate planning and general rationalization

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[31] Another concern involves passing information to a party that does not pose a competitive concern, with the knowledge that the information will ultimately be shared with others with which we would be concerned. See FTC v. Mead, Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent agreement) (complaint alleged, among other things, that letters Mead sent to a number of states "signalling" what it intended to offer in future sealed bids for WIC contracts; Mead "knew or should have known" that the information in the letters would be disseminated to its competitors and that its competitors, in fact, become aware of the contents of the letters.).

Additionally, information sharing can occur under the veil of benchmarking efforts. The FTC recently investigated a case in which, it was alleged, a competitor visited another competitor's manufacturing facility, and during the visit invited them to fix prices on certain products that both companies produce. The parties' defense was that they only went to their competitor's plant to see their competitor's low-cost production processes.

It also possible that another effect of integration is the sharing of information within organizations when parts of the organization directly compete. See Martin Marietta, File No. 941 0038 (consent order accepted for public comment on March 25, 1994); General Motors Corp., 103 F.T.C. 374 (1984), Order Granting Petition to Reopen and Set Aside Order in General Motors Corp., Dkt No. 3132 (Oct. 29, 1993).

of the local health care markets. However, with those efficiencies comes the possibility that sharing the information will lead to collusion.

Moreover, the Clinton Administration's health plan explicitly allows unintegrated provider groups to negotiate collectively with the alliances for fee-for-service schedules.[32] This antitrust immunity does not apply to negotiations with health plans and has important antitrust implications.[33] The most potentially controversial aspect is that it allows for the possibility of coordinated pricing by groups of physicians with market power, which is not allowed in any other context.

Bloch and Falk warn of the proposed plans' anticompetitive potential for spill-over effects.[34] For example, if several individual physicians combine to negotiate a given fee with an alliance in an effort to become a part of a fee-for-service schedule, then those same physicians might later negotiate to become part of a PPO or HMO. They could use the fee information they shared while planning their negotiation with an alliance to then fix the prices they offer the PPO or HMO.

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[32] Health Security Act, Section 1322(c).

[33] By contrast, the Cooper proposal only allows information sharing among providers if there is substantial integration or financial risk-sharing. See H.R. 3222, § 1232.

[34] See Bloch and Falk.

Allowing this type of collaboration on fee-for-service is an attempt to alleviate the concern that the alliances will act as monopsonists given the large number of consumers each alliance will exclusively represent.[35] Yet, it is unclear what efficiencies will be derived from non-integrated providers other than some administrative efficiencies derived from limiting the amount of negotiations. Furthermore, it is questionable whether the alliances will have the ability to act as monopsonists. For example, it may be difficult for the alliances to exclude certain health plans from its listing of plans given the limitations currently in the Clinton plan.[36] This inability would mean that the alliance would not have leverage over plans that will not offer below-competitive pricing. Additionally, alliances cannot guarantee sales to plans as an inducement to lower prices because the consumers make the ultimate choice of health plan, not the alliance.

IV. CONCLUSION

In an earlier article, Mike Riordan, Tom Dahdouh and I suggested that if health care reform resulted in some degree of

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[35] See letter from Kirk B. Johnson, General Counsel, American Medical Association, to Anne K. Bingaman, Assistant Attorney General Antitrust Division, and Janet D. Steiger, Chairman, Federal Trade Commission (Oct. 6, 1993).

[36] Section 1321 of the Clinton plan requires alliances to negotiate with all "state-certified health plans," but permits exclusion of plans that have premiums exceeding 120% of the weighted-average premium or if the plan has filed to comply with requirements under prior contracts with the alliance.

regulation, that regulation might, in turn, lead to a system that permits more consolidation than would have occurred in a health care cost containment approach that relied more heavily on competition. Consolidation is difficult to undo, so that any change in health policy -- say a new policy that relied more heavily on competition -- would confront a different and potentially more difficult cost containment environment.[37] Policy on information exchanges, while perhaps affecting contracting parties, the nature of joint venture and the like, fortunately does not appear to have the same racheting effect.

Finally, it is important to note that the information that is provided in a wide variety of information exchange settings need not always be correct or truthful. To the extent that a hospital, for example, might choose to cheat on a tacit agreement, that cheating could also be manifested in strategic -- that is untruthful -- information disclosure. Absent some means to verify the truthfulness of the supplied information, the value of reported information may be less valuable for detecting cheating than one might otherwise suspect.

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[37] Dennis A. Yao, Michael H. Riordan, Thomas N. Dahdouh "Antitrust and Managed Competition for Health Care," The Antitrust Bulletin (forthcoming Summer 1994).