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The Health Care Competition Report: Insights from the Federal Antitrust Agencies

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On July 23, 2004, the Federal Trade Commission and the Department of Justice released a long-awaited joint report examining competition in the health care sector. The 361-page report, titled *Improving Health Care: A Dose of Competition*, is the result of extensive fact-finding by the agencies based on a 2002 workshop and 27 days of hearings in 2003, during which the agencies received testimony from approximately 250 panelists representing a variety of stakeholders in the health care industry.¹

The Report builds on the agencies' 1996 Joint Statements of Antitrust Enforcement Policy in Healthcare,² and represents the culmination of a massive effort by the agencies to integrate current health policy debates within a competition framework. The Report meticulously summarizes the positions of participants in the workshop and hearings, presenting a competition-oriented perspective on a wide range of health policy issues, including quality initiatives, reimbursement, fraud and abuse, and licensing and credentialing. In it, the agencies outline the evolution of antitrust law in the health care field, and address antitrust issues relating to physicians, hospitals, insurers, health maintenance organizations (HMOs), pharmaceutical companies, and group purchasing organizations (GPOs).

Both the FTC and the DOJ have long-established programs focusing on antitrust enforcement in health care. In their view, particular features of the health care environment make it an especially appropriate candidate for close antitrust scrutiny. These include ex-

tensive government regulation of health care entities, the distortion of incentives resulting from the prevalence of third-party payments (i.e., insurance), the growing cost of health care, and the lack of reliable and accurate information concerning the price and quality of medical services. Yet rather than offering specific policy directives, the Report asserts generally that the agencies prefer "vigorous competition," as opposed to government intervention or industry self-regulation, as the best means of ensuring the delivery of high-quality, cost-effective health care.

A detailed analysis of the voluminous Report is beyond the scope of this article. Nevertheless, certain aspects of the Report summarized below are worth noting.

Physicians. The agencies reiterate their long-standing opposition to allowing independent physicians to negotiate collectively with insurers and other third-party payers. The Report suggests that the agencies will continue to focus on group provider arrangements, including those physician group practices (independent practice associations, or IPAs) and physician-hospital organizations (PHOs), that seek to collectively negotiate, absent concrete evidence that the members are clinically or financially integrated. Indeed, the FTC in particular has been active in recent years challenging IPAs and PHOs that it believes have engaged in unlawful negotiations or price-fixing.³

In response to arguments by providers that collective bargaining is a necessary counterweight to a growing disparity

in bargaining power between insurers and providers, the agencies state that there is no evidence of a monopsony power problem in most health care markets. Even if there were such a problem, the agencies conclude, agency enforcement—not offsetting anticompetitive conduct—is the appropriate solution.

The agencies support the move toward "payment for performance" (or "P4P") initiatives that reward providers for providing quality care, but recognize that implementation of such programs is currently limited by difficulty in obtaining comparative data. The Report suggests that the agencies may consider the existence of a P4P arrangement among physicians as evidence of financial integration even in the absence of traditional financial risk sharing. The Report is less forthcoming on the subject of clinical integration. Despite numerous requests for further guidance, the Report offers little additional information and indicates that they will continue to approach the issue on a case-by-case basis.

Hospitals. The Report contains an extensive discussion of the difficulties of properly defining markets in hospital merger cases. The agencies note that while hospital product markets have traditionally been defined as including all facilities offering acute inpatient care, they are considering whether it would be appropriate in future cases to expand this definition or define new markets to include outpatient care facilities and single-specialty hospitals.

Not surprisingly, the Report is highly criti-

cal of court decisions rejecting the agencies' most recent hospital merger challenges. The Report suggests that courts have adopted unrealistic geographic markets, placed too much emphasis on hospitals' not-for-profit status, and given insufficient weight to payer testimony and hospitals' strategic planning documents.

The Report also notes the agencies' increasing focus on retrospective reviews of completed mergers, which has been of particular significance to Illinois. In February 2004, the FTC issued an administrative complaint challenging the February 2000 merger of Evanston Northwestern Hospital and Highland Park Hospital, alleging that their merger violated Section 7 of the Clayton Act and Section 5 of the FTC Act.⁴ And in July, the FTC announced that it was closing its investigation of the competitive effects of the February 2000 merger of two Waukegan hospitals, Victory Memorial and Provena St. Therese.⁵

Commenting on these retrospective investigations of consummated mergers, the agencies note that such challenges "may present opportunities to assess competitive effects without using detailed market definitions" which, as noted above, have been a significant stumbling block to the agencies' earlier challenges to prospective mergers.

The agencies also reaffirm their position that the institutional status of a facility, i.e., whether it is for-profit or non-profit, should not be considered in determining whether a proposed hospital merger violates the antitrust laws. In addition, the agencies reject the argument that "community commitments" by merging hospitals are an antidote to anticompetitive effects of a proposed merger, but recognize that state Attorneys General faced with limited prosecutorial resources may continue to rely on such commitments in lieu of litigation.

Group Purchasing Organizations. The agencies note that while GPOs have the potential to help hospitals lower costs by aggregating purchasing power, participants at the hearings expressed concern about anticompetitive contracting practices by GPOs, including sole source contracting, bundling of disparate products, and contracts of extended duration. In response to concerns that the 1996 Joint Statements on GPOs immunized such conduct from antitrust scrutiny, the agencies clarified that anticompetitive contracting practices are not covered by

the GPO antitrust safe harbor, and that the agencies will approach complaints about such practices on a case-by-case basis.⁶

Insurers. The agencies note the unsettled state of the law with respect to product market definition in cases involving insurers; specifically, whether HMOs, PPOs, traditional indemnity plans, and self-insurance are properly included in the same market. The agencies acknowledge that they have taken different positions on that issue in different cases, but conclude that the answer to this question will continue to depend on the facts of the specific matter and the still-evolving nature of the managed care market. Regardless of how the market is defined, the agencies will continue to apply the general principles of their Merger Guidelines in evaluating health insurance mergers.⁷

As noted above, the agencies generally downplay concerns expressed by providers about insurer monopsony power. The Report suggests some hostility to complaints by providers that monopsony power has led to lower reimbursement for providers, with the agencies noting that "because one of the purposes of managed care is to lower prices lower to a competitive level, it can be difficult to determine when a managed care purchaser is exercising monopsony power."

The agencies also address the use of "most favored nations" (MFN) clauses by health insurers, which generally provide that the insurer is entitled to the best rate that the contracted provider (such as a physician or hospital) gives to any other insurer, even if that rate is more favorable than the one that it negotiated with the provider. The agencies contend that the traditional justifications for MFNs in other industries, including facilitation of long-term contracts where future price changes and industry conditions are difficult to predict, and difficulty in obtaining price information, are generally not prevalent in the health care sector. Nevertheless, the agencies will continue to consider challenges to MFN clauses on a case-by-case basis.

The agencies also take a position against state laws generally perceived by the public as "pro-consumer," but which restrict the flexibility of insurers to design their product offerings. Specifically, the agencies opposed state mandated benefit laws on the ground that they are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the ranks of

the uninsured by making coverage more expensive. Likewise, the agencies express disapproval of state "any willing provider" or "freedom of choice" laws on the ground that they make it more difficult for insurers to extract discounts from providers and can limit competition among insurers by making it more difficult to differentiate plans by availability of providers.

Pharmaceuticals. The agencies are opposed to pharmaceutical price controls and to other proposals that the government become a direct purchaser of drugs, fearing that "[g]overnment purchasing that reflects monopsony power would likely reduce output and innovation."⁸ For the most part, the Report reiterates the position set forth by the FTC last year that protection of patents and competition in the pharmaceutical industry are the keys to preserving innovation in the pharmaceutical industry.

The agencies also address the debate over the utility of direct-to-consumer advertising by pharmaceutical companies, concluding that the evidence does not support charges by critics that such advertising has led to increased prices for consumers or led to an increase in unwarranted prescriptions. The Report also takes a dim view of legislative efforts to require greater transparency of pharmaceutical benefit manager (PBM) discounts. With respect to both direct-to-consumer advertising and PBM disclosures, the agencies take the position that competition, rather than legislation, will determine the appropriate level of disclosure.

State Conduct. The Report acknowledges the agencies' growing interest in state regulatory schemes that do or have the potential to restrict competition. The Report singles out certificate of need (CON) programs, under which states prohibit new firms from entering certain health care markets unless they can demonstrate that there is an unmet need for their services, arguing that CON requirements pose serious competitive concerns that generally outweigh their purported economic benefits.⁹ The agencies cite evidence that, rather than controlling health care costs, CON programs may drive up prices by erecting anticompetitive barriers to entry. The agencies' concerns are particularly worth noting in light of the recent controversies surrounding the Illinois Health Facilities Planning Board.

In a similar vein, the agencies will con-

tinue to scrutinize actions taken by regulatory commissions or licensing boards that are substantially controlled by incumbent providers for which state action immunity is sought. Last year, for example, the FTC issued an administrative complaint against the South Carolina State Board of Dentistry alleging that it violated federal laws by illegally restricting the ability of dental hygienists to provide preventive dental services, to South Carolina school children.¹⁰

Recommendations. The agencies make six general recommendations for promoting competition in health care markets. First, they encourage private payers, governments, and providers to continue experiments to improve incentives for providers to lower costs and enhance quality for consumers to seek lower prices and better quality. Second, the agencies recommend that states decrease barriers to entry into provider markets, including considering whether to eliminate CON boards and remove certain limits on licensure and telemedicine. Third, the agencies recommend that governments re-examine the role of subsidies in health care markets, though they do not identify particularly categories of subsidies as suspect. Fourth, the agencies encourage legislatures to continue to resist legislation to permit independent physicians to negotiate collectively. Fifth, the agencies recommend that

states carefully evaluate the costs and benefits of proposals to increase transparency by PBMs, reiterating their position that competition rather than regulation is likely to lead to the optimal level of transparency. Sixth, the agencies recommend that governments reevaluate the utility of mandated insurance benefits.

The Report reflects a significant amount of work to ensure that antitrust enforcement policy promotes, rather than hinders, competition in the health care field. While the Report is short on specific policy prescriptions, it is nevertheless significant because it provides a comprehensive and up-to-date perspective on the agencies' enforcement priorities and positions on key topics in health care antitrust. If nothing else, the Report confirms that health care will continue to be a significant enforcement priority for the agencies into the foreseeable future.

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1. The Report, as well as transcripts of the hearings that preceded it, are available on the FTC's Web site at <http://www.ftc.gov/ogc/healthcare-hearings/index.htm>.

2. The Joint Statements are available on the FTC's Web site at <http://www.ftc.gov/reports/>

[hlth3s.htm](#).

3. Report, Chapter 1, page 36 n. 177.

4. The administrative complaint is available at http://www.ftc.gov/os/caselist/0110234/040210_emhcomplaint.pdf (PDF).

5. See <http://www.ftc.gov/os/caselist/0110225/0110225.htm>.

6. On October 1, 2004, Senators Mike DeWine and Herb Kohl introduced the Medical Device Competition Act of 2004 (S. 2880) which, among other things, would direct the Secretary of Health and Human Service, in conjunction with the FTC and DOJ, to promulgate regulations "specifying contracting, business, and ethical practices of persons . . . that are contrary to antitrust law and competitive principles, to ethical standards, or to the goal of ensuring that products necessary for proper patient care or worker safety are readily available to physicians, health care workers, and patients."

7. U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines (1992), available at <http://www.ftc.gov/bc/docs/horizmer.htm>.

8. Report, Executive Summary at 20.

9. In Illinois, for example, firms must demonstrate to the Health Facilities Planning Board that "safeguards are provided which assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest," and that "the proposed project is consistent with the orderly and economic development of such facilities and equipment," among other requirements, to be entitled to a permit to construct new facilities or make certain capital expenditures. 20 ILCS 3960/6.

10. See *In re S.C. State Board of Dentistry*, FTC Docket No. 9311.

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