HEALTH POLICY STATEMENT UPDATE--AHA

1. Existing equipment--The AHA has suggested that we extend Statement 2 (covering purchase of high-tech equipment) to existing equipment. We believe we agree with the FTC and the AHA how to draft a revised Statement to cover this area and are proceeding on that front. We have shared a draft with the FTC, they wish to make one revision. We also need to add an example to flesh out our analysis.

2. Shared Services--The AHA would also like us to extend that Statement to shared services. We have expressed concerns about doing this to them; it is conceivable that a compromise position could be that we would merely explain how we would analyze such situations. This appears to be acceptable to the AHA. We are in the process of working with the FTC on what this Statement would say. It probably would not contain any safety zones, but would discuss how we would analyze such situations.

3. Efficiencies--The AHA has asked us for a Statement describing how we analyze efficiencies in hospital merger analysis. We have told them each case is fact specific, our briefs contain some guidance on these issues and that good guidance is contained in a speech Mary Lou Steptoe gave in June to the PLI on these issues. At our next meeting (tentatively set for July 12) we will discuss with them what more they could want than this guidance.

4. State Action--The AHA wants a Statement on State Action. Both we and the FTC believe this a bad idea from a policy standpoint and that whatever we would put out, if anything, would not be very helpful because it would essentially merely track the language of existing Supreme Court decisions, and probably (at least from the FTC side) read those decisions very narrowly.

5. Multi-provider Network joint ventures--We are exploring with the AHA (and AMA) issues related to multi-provider networks. One of the key issues is integration. The AHA appears to recognize that risk-sharing is a key. We continue to meet with the AHA with respect to this area and still have work to do on a variety of issues, including important issues such as market definition. The FTC is wary about producing anything on this issue because they have not had investigatory experience with these types of networks. We are talking to them in an attempt to get them focused on issuing something relatively narrow to overcome their reluctance, but at the same time something helpful to the provider community. Our last meeting with them indicated this was a possibility. If we issue something, we would like it to include one or more of the examples that would be keyed to the rural concerns we hear from the Hill. This is a major undertaking, and we are in the process of attempting to understand the issues, reach some understanding with the FTC and complete as much as we can as quickly as we can.

June 22, 1994

To: Jennifer Klein

From: Stephanie Cutter

Subject: Florida Hospital Merger

As you requested, below is a brief summation of the settlement between the U.S. Department of Justice, the Florida Attorney General's office, Morton Plant Hospital and Mease Health Care regarding the merger of the two Florida hospitals. This is the first settlement of a case in the health care industry since last fall's release of the Statements of Antitrust Enforcement Policy in the Health Care Arena.

On June 17, the Justice Department and the Florida Attorney General's Office filed a proposed Final Consent Judgment barring the merger of Morton Plant and Mease, which account for nearly 60 percent of the market in the area. The Judgment, however, permits the two hospitals to form a "Partnership", allowing the consolidation and joint operation of certain administrative and patient care services. The "Partnership" will own and operate such services, independent from Morton Plant and Mease, and will sell each service to the two hospitals on the same terms and conditions. A listing of eligible joint services appear on pages two through four of the Judgment.

Further, Morton Plant and Mease may appoint members of their respective boards to a "Partnership" board. Independent services, managed care contracting for Morton Plant or Mease, or the marketing or pricing of any services, including "Partnership" services, may not be discussed by the "Partnership" board and its executives. The "Partnership" board may request Morton Plant and Mease to contribute capital, but each hospital is to determine independently the amount of capital to contribute.

In return for this "Partnership", the proposed Final Consent Judgment decree requires Morton Plant, Mease and the "Partnership" to undertake certain measures to preserve competition in the market. The "Partnership" must establish adequate protections, including employee confidentiality agreements, to keep information regarding pricing, managed care contracts, negotiations with managed care plans, and marketing and planning of the two hospitals separate. Further, Morton

Plant and Mease will continue as separate and competing entities, and will maintain an antitrust compliance program to formally inform their officers, directors, trustees and administrators about the Final Consent Judgment, and to educate them on the meaning of the Judgment and antitrust laws. Finally, to monitor compliance with the Final Consent Judgment, representatives from the Justice Department or the Florida Attorney General's Office are permitted access to Morton Plant and Mease during regular business hours.

Sixty-days after the Justice Department files a Competitive Impact Statement and gives sufficient public notice regarding the Judgment and the Statement, a Final Consent Judgment may be entered by the Court. The Judgment expires five years from the date of entry. However, before the expiration date, the Justice Department or the Florida Attorney General's Office may extend the Judgment at their own discretion for an additional five years.

Department of Justice

FOR IMMEDIATE RELEASE
FRIDAY, JUNE 17, 1994

AT
(202) 616-2771
TDD (202) 514-1888

JUSTICE DEPARTMENT SETTLES FLORIDA HOSPITAL MERGER CASE, DEAL PROVIDES LOWER HEALTH CARE PRICES AND PRESERVES COMPETITION

WASHINGTON, D.C. -- In a trend-setting settlement involving two Florida hospitals, the Justice Department today offered a model on the kinds of consolidations medical providers may do to lower prices while preserving competition.

The lawsuit and settlement, were joined by the Florida Attorney General's office, the first time an antitrust action has been filed jointly by state and federal antitrust enforcers.

The agreement bars the merger of the two largest hospitals in North Pinellas County, near St. Petersburg, while permitting them to jointly provide certain health care services in which competition is plentiful and to share some administrative costs.

"The agreement provides an innovative way to enable the hospitals to achieve cost savings without endangering competition," said Bingaman. "The hospitals must continue to compete on prices to consumers."

Under the agreement, announced jointly with representatives from the Florida Attorney General's office, the two hospitals may form a joint venture partnership for care in which there are

(MORE)

numerous competitors or for which patients might seek attention far from home. The partnership will manage the joint services and will contract to provide them to each of the hospitals at cost. The hospitals would then compete on the price at which they sold those services to consumers which will result in keeping prices competitive.

"The joint services will enable the hospitals to achieve significant cost savings that would unlikely be achieved in other ways," said Bingaman. "Those savings can be passed on to consumers resulting in lower health care prices."

Such partnerships could include, for example, outpatient services which are provided by clinics and doctors' offices, or open-heart surgery, in which hospitals compete in a broad area.

The settlement permits the two hospitals to merge procurement efforts, certain administrative services, telephone services, accounting, billing and collections, and medical records, while providing appropriate confidentiality measures.

The two hospitals account for nearly 60 percent of the market. Morton Plant Hospital is the largest in the area with 672 beds. Its major competitor is Mease Health Care, with 378 beds on two sites.

The action was the first settlement of a case in the health care industry since the issuance of the Statements of Antitrust Enforcement Policy in the Health Care Area, an initiative announced by First Lady Hillary Clinton and Attorney General

Janet Reno last September. The Statements encourage cost-saving joint ventures and joint purchasing agreements while maintaining the benefits of competition.

The proposed consent decree, settles the lawsuit, filed on May 5, in U.S. District Court in Tampa, Florida, in which the Department and the Florida Attorney General alleged that the merger of the two hospitals was likely to lead to higher prices and poorer services for North Pinellas County consumers.

"The merger as originally proposed by the two hospitals which dominate the market in North Pinellas County, would likely have reduced the drive to keep prices down and service up," said Bingaman.

The consent decree, if approved by the court, alleviates the Department's and Florida Attorney General's antitrust concerns.

The case was handled by federal attorneys in the Antitrust Division's Professions and Intellectual Property Section and by Division economists, and by state attorneys in the Florida Attorney General's Antitrust Division.

The proposed consent decree and competitive impact statement will appear in the Federal Register. Written comments may be sent to Gail Kursh, Chief, Professions and Intellectual Property Section, Antitrust Division, U.S. Department of Justice, 555 Fourth Street, N.W., Room 9903, Washington, D.C. 20001.

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94-324

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA and STATE OF FLORIDA, Plaintiffs, v. MORTON PLANT HEALTH SYSTEM, INC. and TRUSTEES OF MEASE HOSPITAL, INC., Defendants.	Civil No. 94-748-CIV-T-23E Judge Steven D. Merryday

FINAL CONSENT JUDGMENT

Plaintiffs, the United States of America and the State of Florida, having filed their Verified Complaint on May 5, 1994, and Plaintiffs and Morton Plant Health System, Inc. and Trustees of Mease Hospital, Inc., by their respective attorneys, having consented to the entry of this Final Consent Judgment without trial or adjudication of any issue of fact or law, and without this Final Consent Judgment constituting evidence against or admission by any party with respect to any issue of fact or law;

NOW, therefore, before the taking of any testimony and without trial or adjudication of any issue of fact or law, it is hereby ORDERED, ADJUDGED AND DECREED:

I.

JURISDICTION

This Court has jurisdiction of the subject matter and each of the parties to this action. The Verified Complaint states a

claim upon which relief may be granted against Morton Plant Health System, Inc. and Trustees of Mease Hospital, Inc. under Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18.

II.

DEFINITIONS

As used in this Final Consent Judgment:

(A) "Eligible Partnership Patient Care Services" means the following patient care services that Morton Plant and Mease may elect to own, manage, operate or provide by the Partnership described herein:

(1) all patient care services provided by Morton Plant or Mease on an outpatient basis that are generally capable of being provided outside of a general acute care hospital;

(2) open-heart surgery and/or services or procedures that require the immediate availability of an open-heart surgery unit;

(3) robotically assisted prosthetic implantation and special spinal instrumentation procedures involving the insertion of multiple rods in the spinal cord;

(4) stem cell procedures, advanced linear accelerator equipment and procedures, and HDR brachy therapy;

(5) stereotactic radio therapy;

(6) inpatient and outpatient diagnostic and therapeutic radiology services (e.g., CAT scans, MRI, X-ray, ultrasound, nuclear angiography);

(7) inpatient and outpatient laboratory services;

(8) neonatal level III services;

(9) inpatient and outpatient mental health services; and

(10) home health care, home infusion services, durable medical equipment, rehabilitative services, skilled nursing, retirement facilities and long-term care.

(B) "Eligible Partnership Administrative Services" means the following administrative services that Morton Plant and Mease may elect to own, manage, operate or provide by the Partnership described herein:

(1) human resources (except management positions at the hospital level with responsibility for management, marketing, planning, pricing or managed care contracting);

(2) medical staff organization and development, including medical staff development and recruitment, physician organization structure, advising on practice acquisition, governance and credentialing;

(3) information services;

(4) telephone and other communication services;

(5) accounting, billing and collection;

(6) housekeeping and laundry;

(7) medical records;

(8) materials management and plant maintenance;

(9) support services for charitable foundations; and

(10) all miscellaneous services not related to patient care and not exceeding an expenditure of $250,000 annually.

(C) "Independent Services" means all services other than those carried out by the Partnership under this Final Consent Judgment.

(D) "Managed Care Plan" means a health maintenance organization, preferred provider organization, or other health services purchasing program that uses financial or other incentives to prevent unnecessary services and includes some form of utilization review.

(E) "Mease" means the Trustees of Mease Hospital, Inc. and all subsidiaries and affiliates.

(F) "Morton Plant" means Morton Plant Health System, Inc. and all subsidiaries and affiliates.

(G) "Partnership" means the nonprofit, tax-exempt organization that Morton Plant and Mease may create and operate in accordance with this Final Consent Judgment.

III.

APPLICABILITY

This Final Consent Judgment applies to Morton Plant and Mease, to the Partnership created by them, to Morton Plant's and

to Mease's officers, directors, trustees, administrators, agents, employees, successors and assigns and to all other persons in active concert or participation with any of them who receive actual notice of this Final Consent Judgment pursuant to F.R.C.P. 65(d).

IV.

PROHIBITED CONDUCT

Morton Plant and Mease shall not consummate their agreement to consolidate as set forth in their Letter of Intent, dated October 19, 1993, or any other agreement to merge, consolidate, or combine, except in accordance with the terms of this Final Consent Judgment.

V.

BONA FIDE PARTNERSHIP

Morton Plant and Mease may enter into a Partnership in which they consolidate and jointly operate certain patient care services and administrative services under the following conditions:

(A) Morton Plant and Mease may agree to consolidate and jointly operate any Eligible Partnership Patient Care Services and any Eligible Partnership Administrative Services.

(B) The Partnership may own and operate any Eligible Partnership Patient Care Service and any Eligible Partnership Administrative Service and may provide such service to Morton Plant and Mease. The Partnership shall sell each service to Morton Plant and Mease on the same terms and conditions in an

amount equal to cost. The Partnership shall conduct an annual cost accounting.

(C) Morton Plant and Mease may appoint members to a Partnership board, which individuals may be members of each hospital's board. Executives at Morton Plant and Mease may also serve as executives of the Partnership and on the boards of their respective hospitals and of the Partnership. The Partnership board will govern the services provided by the Partnership. The Partnership board and its executives may not discuss Independent Services, managed care contracting for Morton Plant or Mease, or the marketing or pricing of any services, including Eligible Partnership Patient Care Services or Eligible Partnership Administrative Services, with the following exception: the Partnership may market and price those services set out in Paragraph II(A)(10) as long as Morton Plant and Mease continue their present practice of providing their patients and physicians with information on other providers of these services in the market. The Partnership board may request Morton Plant and Mease to contribute capital to the Partnership, but each hospital shall exercise its own independent judgment on how much capital to contribute.

(D) Morton Plant and Mease shall provide plaintiffs with written notification of their intent to consolidate and jointly operate any additional or new services (such as pediatrics and neonatal level II services) through the Partnership under the terms of this Final Consent Judgment. Morton Plant and Mease shall also provide any information reasonably necessary for

plaintiffs to assess the competitive impact of adding such services to the Partnership. Morton Plant and Mease may consolidate and jointly operate the additional or new services unless either plaintiff provides a written objection within 120 days of receiving the necessary information. Notwithstanding the foregoing, Morton Plant and Mease may jointly operate through the Partnership any new service not currently provided by Morton Plant or Mease by providing plaintiffs with at least 90-days' notice, so long as the new service is a specialized inpatient procedure commonly recognized in the medical community as "tertiary" or higher, and is performed only by physician subspecialists with specialized support staff and expensive equipment.

(E) Morton Plant may lend or grant Mease up to $21 million for Mease's planned expansion under terms preventing Morton Plant from obtaining any control or leverage over Mease's management or operations.

(F) Morton Plant, Mease and the Partnership may become obligated parties, guarantors or co-makers on debt instruments and the assets of Morton Plant, Mease and the Partnership may be pledged as security for such debt instruments so long as all such obligations are approved separately by Morton Plant and Mease. Neither Morton Plant nor Mease shall unreasonably withhold consent to, impose conditions on, or attempt to influence the use of funds obtained by the other hospital through such financing for Independent Services. In the event that Morton Plant or Mease believes the other has unreasonably withheld such consent,

the matter shall be submitted to binding arbitration under the American Arbitration Association Rules.

(G) Nothing in this Final Consent Judgment is intended to prevent Morton Plant, Mease and/or the Partnership from participating in lawful integrated delivery networks such as accountable health partnerships, physician organizations and physician networks of their medical staff; provided that participation decisions shall be made independently by Morton Plant, Mease and the Partnership.

(H) In the event that federal or state legislation enacted subsequent to the entry of the Final Consent Judgment permits conduct prohibited by this Judgment, Morton Plant and Mease may move for and plaintiffs will reasonably consider an appropriate modification of the Final Consent Judgment. This provision in no way limits Morton Plant's or Mease's right to seek any modification of this Final Consent Judgment.

(I) The Partnership shall establish adequate protections to keep information concerning pricing, managed care contracts, negotiations with managed care plans, and marketing and planning of Morton Plant and Mease separate and to insure that the information of one hospital is not transmitted to or received by the other hospital directly or indirectly. Adequate protections shall include, at a minimum, confidentiality agreements for employees with access to such information and protocols for preparation of separate reports for Morton Plant, Mease, and the Partnership.

(J) The Partnership may make any lawful acquisition of physician practices. However, in the event that a practice is acquired that admits patients to either hospital for Independent Services, Morton Plant and Mease shall allow each such physician to determine in his or her sole discretion to which hospital to admit such patients.

VI.

INDEPENDENT ACTIVITIES

(A) Morton Plant and Mease shall continue as separate and competing corporate entities, with separate Boards of Trustees and executive management, and shall separately own and operate their respective Independent Services. Marketing, pricing, and managed care negotiating and contracting decisions shall remain Independent Services to be considered only in each hospital board's respective meeting. Each board shall adhere to a separate agenda and will record such meeting in separate minutes.

(B) Morton Plant and Mease shall each price and sell its services, both those owned and operated separately and those purchased from the Partnership, in active competition with each other. Morton Plant and Mease shall each exercise its own independent judgment on how to market and price its patient care services and shall not discuss, communicate, or exchange with each other or any other hospital information relating to the marketing, pricing, negotiating, or contracting of any patient care service, including those purchased from the Partnership.

(C) Morton Plant or Mease shall be free to offer any patient care service or administrative service provided through the Partnership independently and in competition with any other provider and may end its provision of any such service through the Partnership.

(D) Morton Plant and Mease shall negotiate and contract independently with health care purchasers such as Managed Care Plans. Morton Plant and Mease may contract with the same Managed Care Plan or any other health care purchaser so long as they do so independently; provided, that Morton Plant and Mease may independently enter into similar but separate contracts with the same Managed Care Plan.

VII.

COMPLIANCE PROGRAM

Morton Plant and Mease shall maintain an antitrust compliance program, which shall include:

(A) distributing within 60 days from the entry of this Final Consent Judgment, a copy of the Final Consent Judgment and Competitive Impact Statement to all officers, directors, trustees and administrators;

(B) distributing in a timely manner a copy of the Final Consent Judgment and Competitive Impact Statement to any person who succeeds to a position described in Paragraph VII(A);

(C) briefing annually those persons designated in Paragraph VII(A) on the meaning and requirements of this Final Consent

Judgment, penalties for violation thereof and the antitrust laws, including potential antitrust concerns raised by hospitals;

(D) obtaining from the officers and administrators an annual written certification that he or she has read, understands and agrees to abide by this Final Consent Judgment and is not aware of any violation of this Final Consent Judgment; and

(E) maintaining for inspection by plaintiffs a record of recipients to whom this Final Consent Judgment and Competitive Impact Statement have been distributed.

VIII.

CERTIFICATIONS

(A) Within 75 days after the entry of this Final Consent Judgment, Morton Plant and Mease shall each certify to plaintiffs whether it has made the distribution of this Final Consent Judgment in accordance with Paragraph VII(A) above.

(B) For five years after the entry of this Final Consent Judgment, on or before its anniversary date, Morton Plant and Mease shall each certify annually to plaintiffs whether it has complied with the provisions of Paragraph VII.

IX.

PLAINTIFFS' ACCESS

For the sole purpose of determining or securing compliance with this Final Consent Judgment, and subject to any recognized privilege, authorized representatives of the United States Department of Justice or the Office of the Attorney General,

State of Florida, upon written request of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General of the State of Florida, respectively, shall on reasonable notice be permitted:

(A) access during regular business hours of Morton Plant and Mease to inspect and copy all records and documents relating to any matters contained in this Final Consent Judgment;

(B) to interview Morton Plant and Mease officers, directors, trustees, administrators, and employees, who may have counsel present, concerning such matters; and

(C) to obtain written reports from Morton Plant and Mease relating to any of the matters contained in the Final Consent Judgment.

X.

JURISDICTION RETAINED

Jurisdiction is retained by this Court for the purpose of enabling any of the parties to this Final Consent Judgment to apply to this Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Consent Judgment, to modify or terminate any of its provisions, to enforce compliance, and to punish violations of its provisions.

XI.

EXPIRATION OF FINAL CONSENT JUDGMENT

This Final Consent Judgment shall expire 5 years from the date of entry; provided that, before the expiration of this Final Consent Judgment, either plaintiff, after consultation with Morton Plant and Mease and in each plaintiff's sole discretion, may extend the Judgment for an additional five years.

XII.

PUBLIC INTEREST DETERMINATION

Entry of this Final Consent Judgment is in the public interest.

Dated:

Steven D. Merryday
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA, and STATE OF FLORIDA, Plaintiffs, v. MORTON PLANT HEALTH SYSTEM, INC., and TRUSTEES OF MEASE HOSPITAL, INC., Defendants.	Civil Action No. 94-748-CIV-T-23E Judge Steven D. Merryday

UNITED STATES' EXPLANATION
OF CONSENT DECREE PROCEDURES

The United States files this memorandum to set forth the procedures regarding entry of the proposed Final Consent Judgment, pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)-(h) (the "APPA"). The APPA applies only to antitrust cases brought by the United States. (The Final Consent Judgment would settle the entire case.)

1. Today, the United States and State of Florida are filing a proposed Final Consent Judgment and a Stipulation between the plaintiffs and defendants in which all parties agree to entry of the proposed Final Consent Judgment.

2. Next week, the United States will file a Competitive Impact Statement relating to the proposed Final Consent Judgment pursuant to the APPA, 15 U.S.C. § 16(b).

3. The APPA, 15 U.S.C. § 16(b)-(c), requires the United States to publish the proposed Final Consent Judgment and

Competitive Impact Statement in the Federal Register and in newspapers 60 days prior to entry of the Final Consent Judgment. The notice will also inform members of the public that they may submit comments about the judgment to the United States Department of Justice, Antitrust Division.

4. The United States will consider any comments it receives and respond to them and publish the comments and responses in the Federal Register.

5. Pursuant to the APPA, 15 U.S.C. § 16(d), at the expiration of the 60-day period, the United States will file with the Court the comments, our responses, and a Motion For Entry of the Final Consent Judgment (unless either plaintiff withdraws its consent to entry of the Final Consent Judgment, as stated in paragraph 2 of the Stipulation filed today).

6. At that time, pursuant to the APPA, 15 U.S.C. § 16(e)-(f), the Final Consent Judgment may be entered without further hearing, if the Court determines that entry is in the public interest.

Dated: June 17, 1994

ANTHONY E. HARRIS, Trial Counsel
JON B. JACOBS
JESSICA N. COHEN
M. LEE DOANE
Attorneys
U.S. Department of Justice
Antitrust Division
555 4th Street, N.W., Rm. 9901
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UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA and STATE OF FLORIDA, Plaintiffs, v. MORTON PLANT HEALTH SYSTEM, INC. and TRUSTEES OF MEASE HOSPITAL, INC., Defendants.	Civ. No. 94-748-CIV-T-23E Judge Steven D. Merryday

STIPULATION

It is stipulated by and between the undersigned parties, by their respective attorneys, that:

1. The Court has jurisdiction over the subject matter of this action and over each of the parties hereto, and venue of this action is proper in the Middle District of Florida;

2. The parties consent that a Final Consent Judgment in the form hereto attached may be filed and entered by the Court, upon the motion of any party or upon the Court's own motion, at any time after compliance with the requirements of the Antitrust Procedures and Penalties Act (15 U.S.C. § 16), and without further notice to any party or other proceedings, provided that plaintiffs have not withdrawn their consent, which they may do at any time before the entry of the proposed Final Judgment by serving notice thereof on defendants and by filing that notice with the Court; and

3. Defendants agree to be bound by the provisions of the proposed Final Consent Judgment pending its approval by the Court. If either plaintiff withdraws its consent, or if the proposed Final Consent Judgment is not entered pursuant to the terms of the Stipulation, this Stipulation shall be of no effect whatsoever, and the making of this Stipulation shall be without prejudice to any party in this or in any other proceeding.

DATED: June 17, 1994.

FOR PLAINTIFFS:

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Attorney General

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FOR DEFENDANTS:

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Date: June 17, 1994
Contact: Emily Stehle, Morton Plant Health System
(813) 461-8117
and
Ed McCarthy, Mease Health Care
(813) 734-6262

FOR IMMEDIATE RELEASE

HOSPITALS ANNOUNCE NEW PARTNERSHIP

CLEARWATER, FL -- Mease Health Care and Morton Plant Health System announced today the formation of a new health care partnership, the result of a settlement with the state and federal government. The new entity, called Morton Plant Mease Health Care, would allow the merging of certain medical and administrative services yet maintain the separate institutions.

"Community benefit is why we presented a full merger back in October," said Frank V. Murphy III, CEO and president of Morton Plant. "And community benefit is why we are agreeing to this settlement."

The two health care systems had announced their intent to merge last fall following a community benefits study that detailed savings of $80 million over a five year period through a full consolidation of the two institutions.

"The settlement reached with the Justice Department is a sincere effort to allow the community to realize the benefits of cost savings, quality enhancement and improved access which will come from our two institutions working together," said Philip K. Beauchamp, CEO and president of Mease Health Care.

"Ninety percent of the cost savings and other community benefits envisioned by a merger could be achieved under the agreement," Murphy said Friday.

-- more --

PARTNERSHIP -- ADD ONE

The new agreement approved by the boards of both hospitals, the Justice Department, the Attorney General's Office and a federal judge allows the two health care systems to consolidate and jointly operate administrative, outpatient and some highly specialized patient care services. Both hospitals would continue to offer routine, inpatient services separately and retain their own boards of trustees and executive management.

Both Murphy and Beauchamp said the settlement "was a step in the right direction."

"We are going forward in response to health care reform," said Murphy. "We believe this settlement is the best decision for the community at this time."

"The settlement is precedent setting, and we are confident the strength of our combined organizations will make it work," added Beauchamp. "We would hope that this will benefit other not-for-profit health care systems in similar circumstances."

-- 30 --

American Hospital Association

AHA

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

January 28, 1994

Anne K. Bingaman
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
10th & Constitution Ave., N.W.
Room 3101
Washington, D.C. 20503

Dear Assistant Attorney General Bingaman:

The issuance of the Statements of Antitrust Enforcement Policy in the Health Care Area ("Policy Statements") on September 15, 1993 was an important first step toward reducing the uncertainty that many providers are experiencing as the health care field consolidates in anticipation of health care reform. The American Hospital Association ("AHA") applauds the Department of Justice ("Department") and the Federal Trade Commission ("FTC") for recognizing the need for health care-specific guidance. As you have agreed, however, additional guidance is necessary. We are pleased to provide you with our suggestions for such guidance.

In response to economic pressures to control costs, hospitals, physicians and other providers are increasingly engaging in cooperative activity in order to provide services more efficiently. The prospect of national health care reform under a "managed competition" model has also encouraged health care providers to form networks and other collaborative arrangements in preparation for dealing with or becoming health plans. Regardless of whether health care legislation is passed in the near future, economic pressure on providers to merge or form joint ventures will continue. In recognition of the trend toward consolidation in the health care field, the AHA believes more guidance from the Agencies is necessary, particularly with respect to the following topics: 1) network formation and operation; 2) joint ventures involving services or existing equipment; 3) efficiency justifications for mergers and joint ventures; and 4) the state action doctrine.

1) Network Formation and Operation

The formation of integrated networks by hospitals, physicians and other providers is by far the most obvious change in the composition of health care markets in the 1990s. The Department and the FTC repeatedly have identified procompetitive effects in

health care markets due to the formation and operation of provider networks.[1]

Networks can take a variety of forms. Some networks involve only specialized services, while others are designed to offer comprehensive services. Some networks are fully integrated, e.g., Kaiser Permanente, with the providers operating within a common legal superstructure, but most networks have been -- and probably will continue to be -- created through a series of contractual arrangements between physicians, hospitals and other providers. While these contractual networks will, themselves, differ significantly from each other, what differentiates them from cartel arrangements is that they all possess some form of partial functional integration, typically taking the form of risk-based pricing, responsibility for utilization review, responsibility for quality assurance or all of the above.

The development of integrated networks, almost by definition, involves increased collaboration among providers. In partially integrated networks, network participants frequently offer jointly derived prices for services and sometimes may agree to reduce unnecessary capacity and duplication in order to achieve significant cost savings. Virtually all networks require the exclusion of some providers, and many also involve exclusive arrangements or the bundling of different services into a single product offering. Effective antitrust policy should articulate

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[1] See Policy Statement No. 6 (reduced prices, utilization review and other limits on the provision of unnecessary care); FTC Enforcement Policy Statement Fed. Reg., Vol. 46, No. 192 at 48984 (1981) (hereinafter "FTC Statement") (a plan may create competition among physicians when it limits the panel of physicians); Letter to David A. Gates from Jeffery I. Zuckerman, Director Bureau of Competition, dated November 5, 1986 at 1 and 3 (hereinafter "Zuckerman Letter") (distinguishes products for consumers and stimulates competition); Department Press Release regarding Stanislaus Preferred Provider Organization, Inc., dated October 12, 1983 at 3 (lowering costs); Letter to Robert Taylor from Charles Rule, Acting Assistant Attorney General, dated October 3, 1986 at 2 (increasing competition among providers and improving service); Letter to F. M. Bush III from Charles Rule, Acting Assistant Attorney General, dated April 7, 1987 at 4 (increasing competition among providers, lowering costs and providing consumers alternatives); Remarks of J. Paul McGrath, Assistant Attorney General, before the American Bar Association dated March 22, 1985 at 2-3 (increasing competition, allowing market influences on price and utilization, consumers given alternatives and lowering costs).

which of these arrangements are permissible and which are objectionable, and, as a consequence, likely to be challenged.[2]

The Need for a Safety Zone for Integrated Networks Involving Hospitals

The sixth Policy Statement establishes a safety zone for certain physician network joint ventures. Many of the networks currently being developed and likely to be encouraged by federal health care policy, however, involve hospitals and other non-physician providers, making a policy statement addressing these networks essential.

Because hospital markets tend to be highly concentrated, the thresholds contained in the physician network safety zone cannot appropriately be applied to fully and partially integrated networks involving hospitals.[3] In order to provide guidance to these networks, the Agencies should build upon the physician network policy statement and establish a safety zone that recognizes the many communities in which there are fewer than five hospitals. Indeed, in discussing the safety zone for physician network joint ventures, the Agencies state that "[i]n relevant markets with less than five physicians in a particular specialty, the physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture" beyond the 20% limit of the safety zone.[4]

In analyzing networks, the primary antitrust concern is that the network not obtain and misuse market power. No hospital, or grouping of hospitals, is likely to possess market power[5] if the

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[2] Our comments are addressed to legitimate networks, those with operational or financial integration.

[3] The physician network safety zone limits physician participation to 20%. In many hospital markets, however, the inclusion of a even single hospital is likely to represent more than 20% of hospital service capacity.

[4] Policy Statement No. 6.

[5] Market power has been defined as the ability to profitably increase prices above competitive levels. Jefferson Parish Hospital Dist. No. 2 v. Hyde, 466 U.S. 2, 27 n.46 (1984); 1992 Horizontal Merger Guidelines, 4 Trade Reg. Rep. ¶ 13,104 at

(continued...)

hospital (or hospitals) in the network have less than 30% of the service capacity in the market.[6] Indeed, vigorous price competition is likely to intensify and thrive whenever three or more integrated networks are able to compete in a market for the business of employers and health plans.

In order to encourage the development of procompetitive networks, whether fully integrated or partially integrated, exclusive or non-exclusive, the AHA recommends that the creation or formation of such a network not be subject to challenge if either of the following conditions is met: 1) with respect to any service that is required by another network to offer a competing product, the network's service capacity is not greater than 30% of the total service capacity in the market;[7] or 2) two other viable networks are operating, or can operate, within the market.

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[5](...continued)
20,570-71 (hereinafter "Merger Guidelines"). In contrast, monopoly power has been characterized as something more than market power. Eastman Kodak Co. v. Image Technical Servs., Inc., 112 S. Ct. 2072, 2090 (1992). Typically, market share is used as a surrogate for market power and monopoly power. Id. at 2081, 2090.

[6] The Department itself has indicated its approval of many similar arrangements. See Remarks of James Rill, Assistant Attorney General, before the National Health Lawyers Association on February 15, 1991 (hereinafter "Rill Remarks"); Letter to George Miron from Anne Bingaman, Assistant Attorney General, dated December 8, 1993; See also FTC Statement at 48991. Although, these statements do not involve exclusive arrangements, courts have indicated that in health care markets, even exclusive arrangements involving not more than 30% are unlikely to create competitive concerns. Jefferson Parish, 466 U.S. at 26; See U.S Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir. 1993); See also U.S. Anchor Mfg. v. Rule Industries, Inc., 7 F.3d 986 (11th Cir. 1993) (a firm with less than 50% of the relevant market cannot have a dangerous probability of achieving monopoly in that market).

[7] Ordinarily, there is sufficient market data to differentiate hospitals by percentage of capacity available. However, the same type of data is not typically available with respect to physicians. Therefore, we anticipate that in most cases the number of network physicians providing a particular service, as a percentage of all physicians providing that service in the market, will be used as a rough surrogate for the physician services capacity of the network for each type of physician service.

Networks Outside the Proposed Safety Zone

Where the formation of networks falls outside of the proposed safety zone, we suggest that rule of reason or merger analysis should be applied. The existence of market power should be the primary focus of any analysis of network formation and operation for networks operating outside the proposed safety zone.[8] Fully and partially integrated networks without market power are unlikely to harm consumers. Therefore, if an integrated network does not have market power, it should generally be free from antitrust scrutiny.

Our conception of some of the issues involved in analyzing these networks follows. While the same principles would apply to all network formation, the application of the principles may vary depending on whether the network is fully integrated or partially integrated and whether the arrangement is exclusive or non-exclusive.

Partially Integrated Networks

Partially integrated networks involving hospitals that fall outside the proposed safety zone, as a general matter, are appropriately subject to rule of reason analysis. Although the rule of reason analysis described in the sixth Policy Statement is also germane to the analysis of such networks, we have identified at least three issues requiring additional clarification: exclusive arrangements, joint pricing and service specialization.

Exclusive Arrangements

The threshold issue in analyzing the contractual arrangements of partially integrated networks is the "foreclosure" effects of exclusive arrangements.[9] Agreements that prevent providers from

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[8] An assessment of market power requires an analysis of the relevant market, which is often a difficult task in the context of network development. The initial focus of the restraint is likely to be in the market for some, or all, provider services. However, many restraints created by the development of networks ultimately may affect a health financing market. Courts have been reluctant to find specialized health care financing markets. U.S. Healthcare, 986 F.2d at 598-9. Nevertheless, any analysis of health care financing markets should determine whether particular financing arrangements represent a separate product market. Id.

[9] U.S. Healthcare, 986 F.2d at 595.

selling their services except through the network (commonly known as "exclusive output contracts") may foreclose health plans not affiliated with the network from purchasing the services of the contracting providers.

If all or most of the physicians or hospitals available to provide primary care services, or one or more critical specialty services -- i.e., obstetrics or cardiology -- are bound by an exclusive arrangement, that arrangement will effectively foreclose competition in the market, although other types of physician or hospital services remain available.[10] In contrast, an exclusive arrangement that only forecloses the supply of medical or hospital services not essential to the operation of a network, or a health plan, would rarely have anticompetitive effects on network services. Therefore, an analysis of the type of services foreclosed is required.

In addition, the duration and termination penalties of the exclusive arrangement may affect its potential foreclosure effects.[11] For example, an exclusive contract for only one year that includes a termination at will provision, without a substantial penalty, is not likely to have any anticompetitive effects, even if a significant number of physicians is involved.

Joint Pricing

The pricing policies of partially integrated networks often raise antitrust questions. However, a simple joint offering of price by independent providers involved in a partially integrated network operating outside the proposed safety zone should not involve any exercise of market power so long as the contractual arrangements are non-exclusive and the offer does not involve any tacit or explicit threat of boycott. To the extent a health plan, or other purchaser, or potential purchaser, objects to a joint pricing proposal, the health plan or purchaser has the option of dealing independently with the network's participants.

The potential purchaser would also be free to make a counter offer to the network. Under these circumstances, the network

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[10] Of course, efficiencies, which are discussed in more detail below, may be sufficient to justify such arrangements.

[11] As noted by the FTC, there are economic reasons that would prevent physicians necessary for competing panels from entering into long-term exclusive arrangements. Zuckerman Letter at 3. However, health plans with market power may be in a position to "force" such physicians into exclusive arrangements.

should be able to negotiate further with the purchaser under pre-set conditions individually established by the network participants. Indeed, the Department has permitted such offerings even in the context of consent decrees with non-integrated networks.[12] Additional guidance in the form of policy statements or guidelines, which are more widely available and carry more force than consent decrees, would be helpful.

Service Specialization

Hospitals forming a partially integrated network may be motivated by a desire to improve the utilization of their respective service capacities in order to achieve better economies of scale. In addition, hospitals may recognize that some members of the network have reached singular levels of excellence in different service areas. To achieve greater economies of scale and take advantage of their strengths in different service areas, the network hospitals may desire to concentrate particular services in individual facilities.

The line dividing "naked" service allocations from cost-saving or quality-enhancing service specializations, as well as the distinction between permissible and impermissible exclusive agreements and joint pricing arrangements, needs to be delineated. The AHA suggests that the example described below can assist the Agencies in articulating the analytical basis for their conclusions.

Hospital A and Hospital B decide to form a hospital/physician network. Hospital A is a traditional community care facility of 150 beds. Hospital B is a 200-bed facility offering primary and secondary level hospital care, with some limited tertiary care services. Unlike Hospital B, Hospital A offers only very limited cardiac care services. The two hospitals are both non-profit, tax exempt, community hospitals with substantial local employer representation on their Boards of Trustees. The only other hospital in the community, Hospital C, is a 300-bed hospital combining some primary and secondary care with a predominantly tertiary care mix.

Hospitals A and B, along with a substantial portion of their medical staffs, form a partially integrated network through non-exclusive contractual arrangements, which include provisions for quality assurance and utilization review. Because the network

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[12] See United States v. Massachusetts Allergy Society, Inc., No. 92-10273H (D. Mass. 1992) (Consent Decree at 2-3).

arrangements are non-exclusive, both hospitals are able to participate in other networks, if such networks are formed.

The network hospitals together represent 55% of the staffed beds in the community and approximately 60% of the licensed physicians. The market is dominated by three large employers, which together comprise 50% of the private health insurance market. Medicare and Medicaid are responsible for approximately 40% of hospital revenues, but 50% of hospital costs. Most of the residents of the community are not willing to seek primary or secondary hospital care from hospitals located in other communities, although some residents are willing to obtain tertiary care elsewhere.

The hospitals agree that they can more effectively service network consumers if all cardiac care cases coming in under network contracts are referred to Hospital B, while all routine OB/GYN will be referred to Hospital A. The hospitals expect that ultimately their network business will comprise up to 65%-70% of their total business and that the volume of non-network business will not be sufficient to support a cost efficient OB/GYN unit at Hospital B or the provision of cardiac care services by Hospital A. The hospitals therefore agree to refer both network and non-network OB/GYN cases to Hospital A, and refer both network and non-network cardiac care cases to Hospital B.

In connection with the network's formation, the two hospitals agree to market jointly a managed care product to the three large employers, as well as to other employers, and all insurance company purchasers. The network wishes to make joint offers regarding both hospital and physician prices on a discounted fee-for-service basis. One of the three large employers has already asked the network whether it would be willing to provide services on the basis of a fee schedule developed by consultants hired by the employer, and the network participants (both hospitals and physicians) have agreed to the schedule. The network wishes to offer the same schedule to all the other employers and insurers doing business in the community.

In addition to the discounted fee-for-service product, the network also wishes to offer a risk-based capitated product. The hospitals agree that they are free to participate in other, non-network capitated arrangements.

- Are the Agencies likely to challenge the formation of the network, or the ancillary agreements relating to the referral of OB/GYN and cardiac care services?

- Would the Agencies object to the discounted fee-for-service joint offering to the employer that requested it? To other employers and insurers? If not, would it matter that the two hospitals and the physicians also have authorized the network to accept counter offers from other employers so long as those counter offers were not more than 10% below the fee schedule initially offered by the network?

- Would the Agencies be likely to object to the offering of the capitated product under these circumstances? Would the Agencies be likely to object to the offering of the capitated product if it were offered on an exclusive basis, with the hospitals agreeing that they would not offer any capitated product except through the network? If the Agencies would object to an exclusivity provision, what difference would it make if the capitated product would not be available but for the provision? To what extent would the term of the exclusive agreement or the restrictiveness of any termination provisions be considered by the Agencies?

Fully Integrated Networks

With respect to fully integrated networks operating outside the proposed safety zone, it is usually appropriate to apply merger analysis. Because hospital markets typically are highly concentrated, a mechanistic application of merger analysis can lead to the incorrect conclusion that the Agencies are likely to challenge hospital participation in such networks. For that reason, the Department and the FTC have acknowledged that the "Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects."[13]

The operation of hospital markets typically differs significantly from the operation of more traditional markets. Hospital markets are characterized by product differentiation and\or substantial overcapacity. In fact, some hospital markets would be natural monopolies once excess capacity is eliminated from the market. Moreover, there are often major purchasers that are able to counteract the bargaining power of the hospitals, even after a merger or acquisition. The Agencies have indicated that at least

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[13] Policy Statement No. 1.

some of these factors could be considered.[14] What is needed, however, is a more complete articulation, in the context of network formation and operation, of the ways in which various factors can counteract the inference of anticompetitive effects created by market concentration. The AHA recommends that the Agencies use the following example to explain how they analyze these factors.

The only two hospitals in a community, both private, non-profit, charitable institutions, form a fully integrated network. One hospital is affiliated with a religious group, and the other is not. The hospitals both provide primary and secondary care, but little tertiary care. Residents of the community are generally unwilling to obtain primary and secondary hospital care in other communities, which are no closer than a 45 minute drive, but are willing to obtain tertiary care elsewhere. The religious hospital has 150 licensed beds and the non-religious hospital has 130 licensed beds. However, the level of staffed beds is low. Specifically, the religious hospital only staffs 110 of its beds, while the non-religious hospital only staffs 90 of its beds.

Two employers comprise 60% of the privately insured population of the community. Medicare and Medicaid represent more than 50% of inpatient hospital revenues. During the past one and one-half years, the average daily census for both hospitals has been between 40 and 50 patients, and consultants hired independently by each hospital have come to the same conclusion: within 5 years the community will only be able to support one hospital, notwithstanding the fact that both hospitals are currently making money. As a favored option, both sets of consultants have independently recommended that the hospitals consider consolidation, as part of a network which would include a new multi-specialty group practice sponsored jointly by the hospitals. The consultants estimate that participation in a new, fully integrated network would reduce the cost of hospital services 10-15%.

The hospitals' participation in the fully integrated network is estimated to provide only one third of the revenue necessary to sustain the consolidated hospital and, as a consequence, it will presumably continue to offer hospital services to other networks, and to patients unaffiliated with any network. The new multi-specialty group would be available on a preferential basis to patients of the integrated network. Nevertheless, there are enough other doctors in the community to support the development of two additional networks, one built around an existing multi-

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[14] See Policy Statement No. 1.

specialty group, and the other an open panel network built around other private practicing physicians currently available in the community.

- Would the Agencies be likely to challenge the creation and\or operation of such a fully integrated network? Would the price of hospital services offered to all the networks be relevant to the Agencies' analysis?

Exclusions From Networks Operating Outside the Proposed Safety Zone

An area of concern to both fully and partially integrated networks operating outside the proposed safety zone is the exclusion of providers. Providers excluded from networks often bring claims for violations of Section 1 of the Sherman Act, asserting that the network is engaging in an illegal boycott.[15] These claims have generally been unsuccessful because the plaintiff has been unable to establish either the existence of market or monopoly power, or anticompetitive effects.[16]

A portion of the nation's population live in sparsely populated regions, and it will not be possible to establish competing networks in all geographic areas.[17] Where networks possess natural monopoly power in either physician or hospital markets, or both, the antitrust laws prohibit networks with such power, or a dangerous probability of attaining such power, from engaging in

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[15] Capital Imaging Assocs. P.C. v. Mohawk Valley Medical Assoc., Inc, 996 F.2d 537 (2nd Cir.), cert. denied, 114 S. Ct. 388 (1993).

[16] Id.; Hassan v. Independent Practice Assocs., 698 F. Supp. 679 (E.D. Mich. 1988); Williamson v. Sacred Heart Hospital, No. 89-30084-RV (N.D. Fla. May 28, 1993) (appeal filed); but see, Hahn v. Oregon Physicians' Serv., 868 F.2d 1022 (9th Cir. 1988), cert. denied, 493 U.S. 846 (1989).

[17] One widely accepted study has concluded that approximately 30% of this country's population live in areas that would not support more than one full service provider network. Kronick, R; Goodman, D; and Wennburg, J., "The Market Place Health Care Reform: The Demographic Limitations of Managed Competition," 328 New England Journal of Medicine, 148 (January 14, 1993).

exclusionary or predatory conduct.[18] When a network with natural monopoly power excludes providers from the network, the conduct may be characterized as predatory or exclusionary.[19]

Nevertheless, the Agencies have recognized procompetitive justifications and market efficiencies associated with the formation of provider networks.[20] Therefore, the mere fact that conduct may exclude competitors of the physicians or hospitals involved in the network should not be determinative. "Liability turns, then, on whether valid business reasons can explain [the defendant's] actions."[21] The Agencies can play a useful role in emphasizing the appropriate analytical considerations that come into play with respect to exclusions from networks.

Tying Contracts Involving Networks Operating Outside the Proposed Safety Zone

A final area of concern to both partially and fully integrated networks operating outside the proposed safety zone is the joint marketing of different services, which may be analyzed as tying contracts under certain circumstances. Technically, tying contracts are governed by per se analysis rather than the rule of reason. Nevertheless, market power remains an essential element in determining liability.[22] Therefore, an agreement between providers of medical services in different relevant product markets to sell their services jointly on an exclusive basis may constitute a tying contract under Section 1 of the Sherman Act if the providers have market power in one or more of the markets. For example, if a hospital with market power in the hospital services market jointly markets its services exclusively with certain physicians on a fee-for-service basis, the conduct is

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[18] Trans Sport, Inc. v. Starter Sportswear, Inc., 964 F.2d 186, 189 (2nd Cir. 1992); see also Spectrum Sports Inc. v. McQullan, 113 S.Ct. 884, 890, 1993; Kodak, 112 S.Ct. at 2090-91.

[19] Alternatively, the conduct could be classified as a boycott, but the analysis would be the same.

[20] Policy Statement No. 6.

[21] Kodak, 112 S.Ct. at 2091 (citing Aspen Skiing Co. v.Aspen Highlands Skiing Corp., 472 U.S. 585, 605); United States v. Aluminum Co. of Am., 148 F.2d 416, 432 (2nd Cir. 1945).

[22] Jefferson Parish, 466 U.S. at 19-22.

likely to be analyzed as a tying contract.[23] In contrast, risk-based products involving both hospital and physician services often must be sold jointly, if at all. If a network offers a single capitation for its package of physician and hospital services on an exclusive basis, the offering should be characterized as a single product. Again, the Agencies could provide useful clarification on this point.

2) Joint Ventures Involving Services or Existing Equipment

The AHA is also seeking additional Agency guidance regarding certain joint ventures. Although the second Policy Statement addresses joint ventures involving new high technology or expensive equipment, it fails to address the joint venturing of existing equipment or new or existing services. The extension of this Policy Statement to such joint ventures would assist hospitals and other providers in their efforts to reduce costs and increase efficiency.

Antitrust Basis for Expansion of Policy Statement.

At its core the second Policy Statement is consistent with traditional antitrust analysis of joint ventures in other industries as well as with other guidelines of the Department and policy speeches of both agencies -- none of which is limited to new equipment ventures. In essence, the Policy Statement addresses the two broad categories of joint ventures that the Supreme Court has recognized as procompetitive: 1) the joint venture that is necessary to make the product or service available at all,[24] which appears to be the basis for the antitrust safety zone; and 2) the joint venture that results in productive efficiencies by producing more output per unit of input.[25]

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[23] Jefferson Parish, Id. at 19, 21-22; Collins v. Associated Pathologists, Ltd, 844 F.2d 473, 477 (7th Cir. 1988), cert. denied, 488 U.S. 852 (1988).

[24] Cf. Broadcast Music, Inc. v. Columbia Broadcasting, Inc., 441 U.S. 1, 23-24 (1979).

[25] Cf. Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985). Cognizable efficiencies include economies of scale, better integration of production facilities and similar efficiencies relating to specific operations of the merging firms. Merger Guidelines § 4.

Significantly, the underlying legal basis of both the safety zone and the rule of reason analysis is not limited to only equipment ventures but is equally applicable to products and services[26] and to existing ventures of both. As one FTC official recently noted:

> Joint ventures normally are created to generate efficiencies, so that an existing product or service can be offered at less cost or that a new product or service can be offered at all.[27]

Applicability to Service Joint Ventures.

The underlying rationale for the second Policy Statement should make it applicable to proposed joint ventures offering services. The existing Policy Statement could be interpreted to provide that clinical services which a hospital cannot profitably offer on its own may be jointly offered; however, in order to avoid confusion, it would be helpful to expand the Policy Statement expressly to include shared services.

The expanded safety zone should treat shared service joint ventures in the same manner it treats joint ventures involving equipment. Therefore, to qualify for an antitrust safety zone, the shared services joint venture may include only the minimum number of hospitals whose participation is necessary to support

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[26] There is no anticompetitive effect when the "joint venture participants do not compete in the joint venture market and are not likely to begin doing so in the near future independently of the joint venture." Department of Justice, Antitrust Enforcement Guidelines for International Operations, § 3.42, 4 Trade Reg. Rep. (CCH) ¶13,109 (1988) (hereinafter "International Guidelines"). Under those circumstances "the joint venture would not eliminate competition, but would increase production capacity in the joint venture market." Id. A venture is less restrictive where "independent pricing, output, or marketing discretion [is reserved] to the individual venture members." Id. at § 3.42; Case 6.

[27] Mark J. Horoschak, Antitrust Perspectives on Joint Venturers Among Health Care Providers, Remarks before the American Bar Association Section of Antitrust Law, 1 (Aug. 11, 1992) (emphasis added) (hereinafter "Horoschak Remarks").

the services;[28] if additional hospitals are included in the venture, they must not be able to offer the service profitably on their own or through the formation of a competing joint venture.

For example, where two hospitals establish a joint venture to provide highly sophisticated oncology services where neither individually provided or could have provided such services, the proposed antitrust safety zone should be applicable. The safety zone would also only protect a single service venture supported by all the hospitals in the community if such a venture were necessary to generate sufficient volume to provide the service on a profitable basis. On the other hand, if the market could support more than one supplier of such service on a profitable basis, a rule of reason analysis would be applicable to assess its legality.

This rule of reason analysis also provides an opportunity for the Agencies to offer guidance with respect to the market power of joint ventures. Where the joint venturers elect to operate jointly owned equipment or to sell a shared service, the permissible market share of the venture is likely to be that permitted under the Merger Guidelines, which under the Herfindahl Hirshman Index is generally 30-35%.[29] Where, however, the joint venturers remain competitors in the sale of the jointly owned equipment or shared service, a higher concentration threshold is appropriate.

Applicability to Existing Equipment or Service Joint Ventures.

The second Policy Statement also fails to address the joint venturing of existing equipment or services. While the antitrust analysis is necessarily more complicated under these circumstances, the approval of such joint ventures is not without precedent,[30] and the antitrust safety zone and tailored rule of

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[28] The objective evidence necessary to qualify for this safety zone would include the cost to provide the service on an annual basis, the minimum numbers of procedures that must be provided annually to reach the financial break-even point, the number of procedures likely to occur within the year given the demographics of the area and the expected price per procedure.

[29] International Guidelines, § 3.42. See also Rill Remarks (collaborative agreement with less than 31.6% of providers in relevant market not viewed as suspect under HHI).

[30] International Guidelines, § 3.42 n. 95.

reason analysis in the Policy Statement offer a means of assessing the anticompetitive effects of joint ventures involving existing equipment or services.

For example, if equipment already purchased by a single hospital is too expensive for the hospital to recover its costs of purchasing, operating and marketing the equipment over its useful life, then the safety zone should allow the hospital to participate in a joint venture with other hospitals that do not own such equipment to the extent necessary to allow all venturers to obtain their costs of purchasing (or using), operating and marketing the equipment over its useful life. Similarly, where a hospital offers a clinical service which, given the cost of offering the service, its patient base is too small to support, then other hospitals which do not offer such service should be allowed to participate in the venture to the extent necessary to provide the requisite patient base to support such service. In both instances the marketplace would dictate the necessity for the consolidation of the existing equipment or services.

Where the other hospitals joining or forming the venture currently own and operate similar equipment, the pooling or replacement of such equipment with jointly owned equipment would be analyzed as a merger outside the proposed safety zone.[31] Similarly, where the other hospitals currently provide a particular service, the joint provision of such service would have the same competitive effect as a merger and should be analyzed as such.[32]

Perhaps the more difficult analysis is where the potential joint venturer could have entered the market independently. Under these circumstances a rule of reason analysis would be

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[31] Horoschak Remarks. However, if the joint venturers each continued to sell products or services in competition with the venture and therefore with each other (such as when two hospitals with separate MRIs, operating at over-capacity, jointly buy and operate a third MRI), or (as in the case of a production joint venture) each separately priced and sold the products of the venture in competition with each other, there would not be the wholesale elimination of competition between the firms, and rule of reason analysis rather than traditional merger analysis should apply.

[32] Cf. International Guidelines, § 3.42; Case 7.

applicable.[33] However, even where two hospitals may not be necessary financially to support a venture of existing equipment or service, there would be circumstances under a rule of reason analysis where the venture would be lawful.

The AHA recommends that, in order to explain how joint ventures of services are analyzed under the rule of reason, the Agencies describe how they would analyze the following example.

In a five-hospital market which, based on the demographics in the market, could financially support two inpatient rehabilitation centers, Hospital A, which does not provide this service, wants to venture with Hospital B, which already provides this service but has additional capacity. Another hospital in the market provides inpatient rehabilitation services. A consultant's report indicates that increased patient volume should increase efficiency from both an economic and quality point of view of the rehabilitation services provided. Hospitals A and B intend to develop a single fee for this service.

- Would the Agencies be likely to challenge the venture? Why or why not?
- Would the Agencies' response be different if, prior to the venture, Hospital B was the only hospital in the market providing inpatient rehabilitation services?
- What additional information, if any, would the Agencies need before making a decision?

3) **Efficiency Justifications for Mergers and Joint Ventures**

Both the Department and the FTC have previously recognized that mergers and joint ventures can be efficiency enhancing. Indeed, in the Merger Guidelines both Agencies recognized that some mergers which might otherwise be challenged may be reasonably necessary to achieve certain net efficiencies. In addition, both Agencies expressed a willingness to consider other efficiencies resulting from reductions in general selling, administrative, and

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[33] See, e.g., Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263 (2nd Cir. 1979) (important consideration is likelihood that one of the venturers would have undertaken similar venture independently).

overhead expenses, although the Agencies indicated that such efficiencies may be difficult to demonstrate.[34]

In previous business review letters, the Department has stated its intention not to challenge certain joint venture arrangements, such as PPO arrangements, which would achieve efficiencies by expediting negotiations and facilitating the contracting process.[35] In other business review letters, the Department has indicated its intention not to challenge PPO arrangements which achieved such efficiencies as centralized billing, claims processing, utilization review for third-parties, joint marketing, and debt collection.[36]

Although the above statements purport to recognize that certain efficiencies can justify mergers or joint ventures that might otherwise be challenged, health care providers need better to understand how the Agencies balance the achievement of efficiencies against the potential lessening of competition between the parties to a merger or joint venture. The Merger Guidelines seem to contemplate a sliding scale -- requiring greater net efficiencies if the merger has greater potential anticompetitive effects.[37] Therefore, if the efficiencies achieved from a joint venture or merger are likely to be substantial and the anticompetitive effects are likely to be

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[34] Given the significant over-capacity of beds in the hospital industry, primarily due to prior government encouragement of hospital construction under the Hill-Burton Act, mergers of hospitals will have more potential to achieve efficiencies than would be likely in almost any other industry.

[35] See Letter to Gregory G. Binford, Esq. from Mark Gidley, Acting Assistant Attorney General, dated January 7, 1993, stating no enforcement intention to challenge Case Western Reserve University School of Medicine and University Hospital Cleveland plan to use a single agent to negotiate contract terms and fees with third-party payors on behalf of 13 separate physician practice groups providing care at University Hospital. The Department viewed these groups as not competing with one another.

[36] See Letter to Frank Sanchez from Charles Rule, Acting Assistant Attorney General, dated October 3, 1986, stating no intention to challenge a pharmacy joint venture called Service For You which would negotiate contracts for pharmacy members with third-party payors to provide drugs and services to subscribers of the third-party payors.

[37] See Merger Guidelines, § 4.

insignificant, such as a merger or joint venture in a community where other competitors still remain after the merger or joint venture, in contrast to a community where no competitor (or only one) would remain in the relevant market, then the efficiencies should overcome concern over potential anticompetitive effects. It is not clear, however, how the Agencies view these and other factors.

To clarify the Agencies' position on efficiencies, the AHA suggests additional guidance addressing the following questions:

- To what extent does the existence of strong competition remaining in the geographical area influence the Agencies to give more weight to the efficiencies generated by the merger or joint venture?

- If the joint venture will result in cost-savings, will the Agencies view the transaction more favorably if the venture is non-exclusive, rather than exclusive?

- What types of efficiencies (or what amounts saved as a result of the merger or joint venture) would the Agencies find sufficient so as not to challenge a particular merger or joint venture?

- If outside consultants identify the types and amounts of efficiencies at an early stage before the transaction is completed, will the Agencies view the estimate more favorably than if the estimate is made after the agreement is executed?

- If the joint venture will increase the potential for improving the quality of care by the venturers, will this enhancement of quality be an important efficiency in the view of the Agencies?

To address these issues, the Agencies might consider using the following example.

Assume there are five hospitals in a relevant geographic market, and currently three hospitals offer cardiac catheterization services and one of those also offers open-heart surgical services. Hospital A operates its cardiac catheterization services at an annual profit of $100,000. (Hospital A is also the only facility in the area approved by the State to provide open-heart surgical services.) Hospitals B and C provide only cardiac catheterization services and have reported losses of $100,000 each for the past three years in providing those services.

Hospitals B and C commission a study by the health consulting subsidiary of a Big Six Accounting Firm, which concludes that if Hospitals B and C were to joint venture their existing cardiac catheterization services, they could save a total of $250,000 per year through eliminating the duplication of staff and equipment and agreeing that all cardiac catheterization services will be performed at Hospital B. The study also concludes that the hospitals might be able to generate a sufficiently high volume of procedures together so as to satisfy the minimum State standards for establishing an open-heart program. The State, however, would still retain the right to approve such a program, so there is no guarantee that the open-heart application would be granted.

Hospitals B and C believe that by operating their own joint cardiac catheterization program they would then be able to recruit more cardiac surgeons to the community, and ensure that the two hospitals could compete more effectively with Hospital A for managed care contracts requiring provision of cardiac catheterization procedures, and potentially for provision of open-heart services.

- **Based on the efficiencies expected to be achieved in the above example, would the Agencies be likely to challenge the joint venture?**

- **Would the Agencies have any different view if there would be at least two other hospitals offering cardiac catheterization services, rather than only Hospital A, after Hospitals B and C formed the joint venture?**

- **Would the Agencies view the efficiencies differently if Hospitals B and C were not currently losing money, but instead were merely breaking even on their existing cardiac catheterization services?**

- **What additional information, if any, would the Agencies need before determining whether the efficiencies generated by the proposed joint venture would exceed any competitive harms caused by the venture?**

4) <u>State Action Doctrine</u>

In the last two years, at least 15 states have enacted special laws to facilitate cooperative agreements between hospitals and

other health care providers.[38] These enactments -- frequently termed "hospital cooperation acts" -- involve some type of state regulation and approval of arrangements between otherwise competing hospitals or hospitals and other health care providers.[39] The statutes almost always contain provisions by which the state's approval of the cooperative arrangement is intended to confer an exemption from the state's antitrust laws and "state action immunity" from liability under federal antitrust laws.

While the Supreme Court has provided reasonably clear guidance on what a state statutory regime must provide in order to satisfy the first of the two state action immunity criteria -- articulating a policy to displace competition with regulation -- and the various state hospital cooperation acts appear to meet these standards,[40] there has been little guidance concerning the second criterion -- active state supervision of the potentially or actually anticompetitive conduct. The decision in F.T.C. v. Ticor Title Ins. Co.,[41] which rejected state action immunity for so-called "negative option" rate regulation, has engendered some uncertainty concerning the efficacy of the various state hospital cooperation acts in affording state action immunity on state-approved arrangements. As the former Director of the FTC's Bureau of Competition observed:

> Whether the [hospital cooperation acts] will indeed confer any federal immunity after the Ticor decision is open to question. Ticor emphasizes the importance of limiting "state action" immunity for private actions to cases where the state effectively oversees what is being done in its name. It remains to be seen how closely states will scrutinize private decisions

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[38] See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); Colorado Hospital Efficiency and Co-operation Act (Colo. Rev. Stat. 24-32-2701 et seq).

[39] See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); North Carolina (NC Stat. § 131E-192.1); Washington (R.C.W. § 15.21.020).

[40] See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); North Carolina (NC Stat. § 131E-192.1).

[41] 112 S.Ct. 2169, 119 L.Ed.2d 410 (1992).

> approved under the statutes and regulate their implementation.[42]

More recently, in a staff letter to North Dakota's Assistant Attorney General, the FTC's Office of Consumer and Competition Advocacy questioned whether two bills then pending before the North Dakota legislature would require sufficient state supervision to confer state action immunity for state-approved agreements between health care providers:

> Both of these bills would require that applications for certificates be reviewed and specifically approved before the certificates would be issued, but neither calls for subsequent scrutiny of the parties' actual operation, except by providing generally for the possibility of reexamination and revocation. More particularized scrutiny of actual conduct under these agreements may not only be desirable to ensure that they continue to serve their intended purposes, but might also be necessary to accomplish the apparent goal of conferring antitrust immunity.[43]

This uncertainty should be resolved. As one commentator aptly put it:

> It would be a terrible result if providers rely upon [these] statutes in entering into cooperative

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[42] "The Role of Antitrust in Improving And Reforming the Health Care System," Remarks of Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, before the ABA Section of Antitrust Law and Health Law Forum, New Orleans, Louisiana, October 15, 1992, pp. 2-3. Private commentators have made similar observations. See H. Feller, "The Impact of Ticor on State Legislation Authorizing Provider Collaboration," Antitrust Health Care Chronicle, Vol. 7, No. 2 (1993) (suggesting that state hospital cooperation acts cannot assure state action immunity for state approved collaborative arrangements unless there is mandatory annual review and re-approval of the arrangement); K. Grady, "The Role of Antitrust in a Reformed Health Care System," Antitrust, Vol. 8, No. 1 (Fall 1993), p. 4. ("Initially, there may be antitrust litigation over whether activities consistent with state statutes qualify for state action immunity.")

[43] Letter, Michael O. Wise, Acting Director, Office of Consumer and Competition Advocacy, Federal Trade Commission, to The Honorable David W. Huey, Assistant Attorney General, State of North Dakota, March 8, 1993, p.13 (hereinafter "Wise Letter").

> agreements, and then later learn that their activities are not immune from the federal antitrust laws because the state agencies have not sufficiently monitored or supervised the approved cooperative arrangements.[44]

The Clinton Administration has likewise recognized the need for certainty in this area, indicating in its September 7, 1993 summary of the Health Security Act that "the Department of Justice and the Federal Trade Commission [should] publish guidelines that apply the 'state action doctrine' where a state seeks to grant antitrust immunity to hospitals and other institutional health providers."[45]

Consistent with these pronouncements, and the demonstrated willingness of the Department and the FTC to set forth their views to state officials on the antitrust consequences of state legislative and regulatory initiatives in the health care sector,[46] the AHA respectfully suggests that the Agencies clarify their approach to the "active supervision" requirement of the state action immunity doctrine in the context of state hospital cooperative acts. We believe that the example described on Pages 7-8 of this letter can also serve as a useful example upon which the agencies can frame a clear explanation of their position regarding "active supervision." In addition:

Assume that because they recognize that their arrangement might be viewed as anticompetitive, the two hospitals forming the network described above apply for a certificate of public advantage from a state health agency under the state's hospital cooperation act. The act expressly authorizes the state agency to review and approve cooperative agreements between hospitals if it determines that the benefits from such arrangements outweigh their anticompetitive effects. The agency grants the certificate after concluding that the network will likely provide a favorable balance of benefits to its citizens. In its written decision, the agency concludes that the market for the network services will consist mainly of large "power" buyers, that the hospitals

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[44] See H. Feller, n. 42, supra.

[45] Summary, "American Health Security Act of 1993," September 7, 1993, p. 170, reprinted in BNA Health Care Policy Report, Special Supplement, September 13, 1993.

[46] See Letter, Anne. K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to the Honorable Cynthia M. Maleski, Insurance Commissioner, Commonwealth of Pennsylvania, September 7, 1993; Wise Letter, n. 43, supra.

are not likely to charge a supra-competitive price because of the employer representatives on their Boards, and that patients and payors are likely to benefit from the unit cost reductions associated with allocation of services and improvements in quality attributable to a higher frequency of cardiac care procedures at Hospital B.

The certificate contains a provision requiring the hospitals to file biannually a report with the agency detailing their network activities, including any change in their charges from preceding years and the reasons therefore. State law grants to the agency the authority to seek a court-ordered revocation of the certificate upon a showing that, as a result of changed conditions, the benefits from the arrangement no longer outweigh its anticompetitive effects.

In this situation, where there is state review and approval of the network upon its formation, combined with the requirement of biannual reporting to the state and the state agency's power to seek a revocation of the certificate, is any additional state supervision of the activities of the hospitals necessary to secure "state action" immunity for formation and operation of the network?

If this is not sufficient, which (if any) of the following would be necessary or sufficient to satisfy the active state supervision requirement, and with what frequency?

- The state agency affirmatively re-approving the arrangement? If so, how frequently?

- The state agency approving the hospitals' charges, or approving the hospitals' budgets, or establishing revenue limits for the hospitals?

If the state supervises the activities of the hospitals in the network through revenue, charge or budget controls, is it also necessary for state action immunity that the state review and approve the non-price terms of the contract between the hospitals and payors?

- For example, if a payor requests that the hospital network provide nurse midwife services, but the hospitals decline to do so, must the state affirmatively approve the hospitals' decision not to offer such services?

Conclusion

The AHA appreciates your personal commitment to reducing the uncertainty that health care providers currently face when engaging in joint activities. In this letter we have addressed a number of areas where this uncertainty is most troublesome to providers. Although these issues are complex, their resolution is crucial to encouraging and promoting the reform of our health care delivery and financing systems.

Because the health care field is changing rapidly in anticipation of legislative health care reform, additional guidance is needed as quickly as possible. Joint guidance from the Department and FTC would be particularly welcome, and I therefore urge you to share this letter with the FTC.

I will contact you shortly to discuss how the AHA can best assist you in the development of additional guidance. In the meantime, if you have any questions, please do not hesitate to contact me at (312) 280-6121 or Tracey Fletcher of my staff at (312) 280-6674.

Sincerely,

Fredric J. Entin
Senior Vice President
and General Counsel

Jen
Kline

U.S. Department of Justice

Antitrust Division

Washington, D.C. 20530

[4843b]

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COMMENTS: May be of interest. Last years FTC presentation

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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

Mr. Chairman and members of the Subcommittee: I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust enforcement and health care reform.[1]

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

There is intense interest in proposals for containing the rapidly increasing cost of health care in the United States. I am not, of course, in a position to discuss any particular proposal,[2] but as Chairman of an agency that has for years been an advocate and defender of the role of competition in health care, I want to discuss an element that has figured prominently in the reform discussions to date -- reliance on competition in the health care field, including the development of managed care and other alternative delivery plans.

I have two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform. I will not suggest that any particular antitrust exemption would doom any particular health care plan. However, proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate

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[2] The Administration's Health Care Reform Task Force is currently scheduled to announce its proposals during May.

the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost reductions.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. Instead, the Commission endeavors to keep markets competitive so that consumers may choose whatever health care option they prefer. We do not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, we try to level the playing field so that each plan may develop and grow as they meet the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede or block the development of health care alternatives that consumers might elect to use. This background on the function of the Commission in enforcing the antitrust laws is a useful starting point for understanding our role in this process.

Through sound antitrust enforcement the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care

delivery systems grew as consumers were attracted by the services or lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust enforcement.

Before I develop these points in greater detail, however, let me offer a general caveat. Although I firmly believe that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. My suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. I believe that the Federal Trade Commission will continue to play a significant, constructive role in this process.

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

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970s, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multi-specialty group practices were rare, and health care plans that sought to compete by signing up a limited panel of selected physicians were impeded by a variety of restrictions. Most

hospitals operated in a similarly independent fashion, with few limitations on what they could charge.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges.[3] In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization.[4] The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, providers of alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or Health Maintenance Organization ("HMO"),

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

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

"underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.[3]

HMOs and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offered are worth accepting their limitations. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to operate effectively.

The advertising aspect of the Commission's AMA case also benefited consumers. Doctors had been prohibited by the AMA's ethical rules from disseminating truthful information to the public about the price, quality, or other aspects of their services (such as office hours, acceptance of Medicare assignment or credit cards, use of Spanish-speaking staff, or house-call

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

services).[6] The Commission found that this ban on truthful advertising had a particularly adverse impact on newly emerging plans such as HMOs, which needed to advertise precisely because they were novel, and thus unfamiliar to consumers.[7] The ability to advertise is particularly important to a new market entrant.

Even after the Commission's AMA case freed physicians to affiliate with health care plans, these plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, our experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy conduct such as obstructing hospital privileges for HMO physicians[8] and boycotting a hospital that was planning to open an HMO facility.[9]

Within the last two years alone, the Commission has issued a series of orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic.[10] The

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[6] See Id. at 846-48. See also Broward County Medical Society, 99 F.T.C. 622, 624 (1982) (consent order).

[7] 94 F.T.C. at 1006.

[8] Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

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

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

(continued...)

Cleveland Clinic is a nationally known provider of comprehensive health care services. The Clinic, which operates as a multi-specialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. Our orders prevent such activity from recurring.

The Commission also played an important role in taking enforcement action to end barriers to the emergence of independent health care prepayment plans. The first medical and hospital prepayment plans -- forerunners of today's Blue Cross and Blue Shield plans -- were outgrowths of state or local medical societies and hospital associations. These groups initially had direct control of the plans, but in the early 1970s the Blue Cross plans began to split off from the hospital associations. Provider control of Blue Shield plans lasted longer. An important factor in the debate about provider control of Blue Shield plans was a Commission staff report detailing evidence that medical societies had used control of the plans to

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[10](...continued)
of Broward General Medical Center, C-3344, 56 Fed. Reg. 49,184 (1991) (consent order).

increase physicians' fees and to obstruct competition from non-physician providers and from health care plans.[11]

One of the first Blue Shield plans to become independent of a medical society was Blue Shield of Michigan. Once independent, this plan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In Michigan State Medical Society, the Commission prohibited such joint "negotiations."[12]

The Commission has since enjoined a number of other conspiracies to obstruct cost containment measures, in cases such as Federal Trade Commission v. Indiana Federation of Dentists,[13] where the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the efficient operation of utilization control mechanisms.[14] More recently, we obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply

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

[12] 101 F.T.C. 191, 296, 313-14 (1983).

[13] Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447 (1986).

[14] Id. at 461.

operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.[15]

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, our review of hospital mergers, as I will discuss later, helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives.

The antitrust enforcement actions I have just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus expand the variety of health care plans, particularly more cost-containment options. For example, the Commission has brought cases that challenged unjustified restrictions on the delivery of health care services by non-physician providers, such as nurse-midwives or podiatrists.[16] The Commission does not side with non-physicians against physicians, or vice versa, of course, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able -- so far as possible -- to compete on a level playing field. The resulting expanded

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[15] Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992).

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

range of choice benefits both health care plans and individual health care consumers.

The Commission has also acted against provider efforts that directly sought to frustrate cost-containment programs. The Commission has entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.[17]

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. Last year, the Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[18] This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, $20 million a year.[19]

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[17] E.g., Southeast Colorado Pharmacal Ass'n, C-3410, 57 Fed. Reg. 52,631 (1993) (consent order); Peterson Drug Company, No. D-9227 (1992) (Commission adopted opinion of administrative law judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D-9227, 56 Fed. Reg. 9223 (1991); Orange County Pharmaceutical Soc'y, No. C-3292, 55 Fed. Reg. 31,441 (1990) (consent orders).

[18] Sandoz Pharmaceutical Corp., C-3385, 57 Fed. Reg. 36,403 (1992) (consent order).

[19] This was one of two tying cases brought by the Commission. In the other case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, No. C-3290, 55 Fed. Reg. 27,686 (1990) (consent order).

Last year, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WIC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WIC program.[20]

Finally, I would be remiss if I did not mention some of the merger cases brought by the Commission in the health care area. In addition to the hospital merger cases, which I will discuss later, in the last three years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone, and wheelchair lifts.[21] By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the

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[20] FTC v. Mead Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent order); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992) (consent order). The Commission is also pursuing allegations of price fixing against a third manufacturer which did not agree to settle the Commission's allegations. FTC v. Abbott Laboratories, 1992-2 Trade Cas. (CCH) ¶ 69,996 (D.D.C. 1992).

[21] Dentsply International, Inc., C-3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C-3331, 56 Fed. Reg. 26,108 (1991) (consent order); Roche Holding Ltd., C-3315, 55 Fed. Reg. 53,191 (1990) (consent order).

Commission's merger enforcement contributes to the overall health care cost containment effort.

II. Antitrust Exemptions and Health Care Reform

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. Our experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures from antitrust scrutiny. Others seek an exemption for various forms of concerted action -- in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and tals may be based on questionable arguments about the nature tition in health care markets and how antitrust law physicians and hospitals. One argument is that due to

as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

A. Hospital Exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents pose two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. We believe that the available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. Let me put the issue in

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

Our assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed by some others. Hospital merger and joint venture activity has been so vigorous that a recent article in Modern Healthcare was entitled "Mergers Thrive Despite Wailing About Adversity."[22] After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Similarly, a Department of Health and Human Services task force recently examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.[23]

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

[23] Report of the Secretary's Task Force on Hospital Mergers, at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions.

The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings."[24] We believe that the task force report supports our contention that antitrust enforcement does not inhibit efficient mergers in the hospital area.

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of our merger enforcement, we have expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.[25]

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[24] Id. at 9.

[25] University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) (consent order) (exempting a wide range of support service joint ventures). See Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). See also The Reading Hospital, FTC Docket No. C-3284, 55 Fed. Reg.

(continued...)

These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

The great majority of hospital mergers and joint ventures -- like those in most lines of business -- do not endanger competition. Most hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition.

Similarly, many hospital joint ventures are efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some forms of joint venture activity. To cite but one example, virtually all

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[25](...continued)
3264, 3266, 15,290 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory and biomedical equipment repair services).

hospitals acquire many of their day-to-day supplies through buying cooperatives.[26]

But the fact that most hospital mergers and joint ventures are procompetitive does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In our hospital merger investigations, we examine a broad range of evidence concerning the likely impact of the merger on health care costs. We do not rely on market concentration figures standing alone. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When we review hospital mergers, we consider whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

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[26] See Nearly All Hospitals Use Group Purchasing, Modern Healthcare, Dec. 24-31, 1990, at 40.

Finally, let me address the argument that merger enforcement in the health care area actually leads to higher, not lower health care costs. The argument we hear with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission by Hospital Corporation of America in defense of a proposed merger a few years ago. The Commission found that the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector . . . will allow natural market forces to slow the price spiral."[77]

The Commission's experience in merger enforcement in the health care area has demonstrated that often procompetitive mergers can result in the elimination of duplication of services. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. The Commission is aware, however, that care must be given to ensure that eliminating duplication of services does not become simply avoiding competition.

B. Exemptions for Professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of

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

health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-containment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but

rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, we are not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

But we need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the Michigan State Medical Society case I mentioned. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The point is straightforward. Physicians can engage in forceful

advocacy and provide information to health plans without an antitrust exemption.[28] The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).[29] But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately we have also heard the claim that antitrust enforcement interferes with responsible self-regulation by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Let me assure you that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet minimal quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.[30] As the Commission emphasized in

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[28] The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the Chain Pharmacy Association matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12,534, 12,541 (1991).

[29] See, e.g., Southbank IPA, Inc., C-3355, 56 Fed. Reg. 50912, 50914 (1991); 57 Fed. Reg. 2913 (1992); Rochester Anesthesiologists (formerly Jose F. Calimlim, M.D.), 110 F.T.C. 175, 180-81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307-08, 314 (1983).

[30] See American Psychological Ass'n, C-3406, 58 Fed. Reg. 557 (1993) (Commissioner Azcuenaga concurred in part and dissented in part); National Association of Social Workers, C-3416, 57 Fed. Reg. 61,424 (1992) (Commissioner Starek dissented).

its 1979 opinion in the AMA case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.[31]

Before leaving the subject of self-regulation, let me also say a brief word about the AMA's request for an FTC advisory opinion on peer review of doctor's fees by medical societies, because I have heard several public references to it recently. More than a decade ago the Commission approved the concept of advisory fee review by professional organizations.[32] Such programs can provide valuable information to patients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns. The AMA has asked the Commission to approve a type of fee review that goes beyond the kind of peer review that has been approved in the past, because it would involve not only the provision of information to consumers about the reasonableness of specific fees, but also possible disciplinary action against physicians in certain circumstances.

In order to analyze the AMA's proposal, several months ago the Commission's staff asked the AMA to provide additional

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[31] American Medical Ass'n, 94 F.T.C. at 1029.

[32] Iowa Dental Ass'n, 99 F.T.C. 648 (1982) (advisory opinion approving proposal of dental association to institute a peer review program which would aid the cost containment efforts of third-party payers, so long as the fee review program was voluntary and non-binding, guidance in particular disputes was not disseminated to members generally as an indication of appropriate pricing, and the judgments of the peer review panel did not proceed from pre-agreed price standards).

information and to clarify certain aspects of the proposal. It is my understanding that the information has been received and that FTC staff and AMA representatives conferred in late February. This new information is now under review and the Commission intends to resolve the matter expeditiously.

Conclusion

I thank the Committee for the opportunity to present this testimony. I will now be happy to answer your questions.