COUNCIL ON THE ECONOMIC IMPACT OF HEALTH CARE REFORM

BRANDEIS UNIVERSITY • WALTHAM • MASSACHUSETTS

AGENDA
COUNCIL MEETING 11/28/94

The Madison Hotel
Fifteenth & M Streets, N.W., Washington, D.C.
Mount Vernon Salons A&B
10:30 a.m. - 5:00 p.m.

10:00	Coffee
10:30	Welcome - Stuart Altman
10:40	Overview: Market Concentration, Antitrust, and Public Policy in the Health Care Sector - David Shactman
11:00	The Case for Strong Antitrust Enforcement: • Glenn Melnick - Associate Professor UCLA School of Public Health • Alphonso O'Neil-White - Vice President and General Counsel, Group Health Association of America
11:30	The Case for a More Flexible Antitrust Policy: • William G. Kopit - Epstein, Becker and Green, P.C. • John Horty - Horty, Spring, Mettern, and Symons
12:00	Discussion
12:30	Luncheon - Presentation by Congressman William M. Thomas, Ranking Republican, Health Subcommittee, Committee on Ways and Means
2:00	Break
2:15	Continued Discussion on Antitrust
3:30	Further Actions the Council Will Undertake on Antitrust
4:00	Procedural Issues
4:30	Closing Remarks and Scheduling of Next Council Meeting
5:00	Meeting Adjourns

The Council is supported by a grant from The Robert Wood Johnson Foundation and is administered by the Institute for Health Policy.
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Brandeis
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News

For Immediate Release:
Nov. 16, 1994

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National Health Experts to Examine How Mergers Are Transforming the Health Industry Without Overall Reform

Although Congress failed to pass health care reform this year, the industry is reforming itself through unprecedented mergers of hospitals and health organizations that may determine the future of the U.S. health care system.

That consolidation will affect the health care of all Americans, but changes are taking place without a national policy and public debate.

A non-partisan council of noted health care experts and economists, chaired by Stuart H. Altman of Brandeis University's Heller Graduate School, will meet Nov. 28 in Washington, D.C., to discuss the complex issues surrounding market consolidation and antitrust.

The Council on the Economic Impact of Health Care Reform, which is administered by Brandeis and funded by a Robert Wood Johnson Foundation grant, aims to alert public policy makers, members of the health care community, and the public to the importance of these issues.

"Congress may not be focused on health care reform right now," Altman said. "But the issue is not going away."

With no national policy, the antitrust departments of the Federal Trade Commission and the Department of Justice have become the unlikely arbiters of these hospital mergers. Altman, one of the country's foremost health care economists, and David Shactman, the council's senior analyst, have been reviewing government policies, laws, and regulations on the issues. They have been talking with key people in the Department of Justice and on the Federal Trade Commission, and with hospital association leaders, lawyers, and congressional staffers.

- more -

Significant issues, such as the impact of consolidated hospitals on the community, must be addressed, said Altman, the Sol C. Chaikin Professor of National Health Policy at Brandeis.

"Can these large hospital systems efficiently allocate medical resources for their communities better than more purely competitive markets?" he asked. "If they acquire market power will they use it to minimize cost and support their charitable and educational missions, or will they raise prices?"

Health care became a hot political topic in 1991, when 37 million Americans were uninsured and another 20 to 30 million were at risk of losing their insurance. By 1993, however, health maintenance organizations (HMOs) were a major factor in a substantial reduction in the rate of increase in health care costs, although close to 40 million Americans were uninsured, Altman said. HMOs bargained aggressively for discounts from hospitals and physicians, who responded by engaging in a record number of mergers, acquisitions, and joint ventures.

"Such consolidation offers the potential for a more efficient delivery system and an enhanced ability for hospitals and doctors to bargain more effectively with managed plans," Shactman said. "But it may also give them enough market power to raise prices and increase profits. In a very real sense, the future structure of the health delivery system may well be defined by the struggle between these two forces."

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CONSUMER PROTECTIONS

Businesses and individuals who have insurance today should be able to keep it, even if they get sick or change jobs.

Businesses and individuals should be protected from unfair or discriminatory insurance practices.

Reforms should emphasize the principle of insurance: the broad spreading of risk.

Small businesses and individuals should have the same opportunities to obtain affordable coverage that larger businesses have.

Reforms should not restrict individuals from choosing their own physician or hospital.

Individuals and businesses should have better information to make purchasing decisions.

Reforms should encourage health plans and providers to improve quality of health care.

COVERAGE

Any reform legislation must provide for progress that puts us on the path towards universal coverage.

Reform should maintain an adequate safety net for those who cannot obtain or afford private insurance.

COST CONTAINMENT

Cost containment should make the delivery of health care more efficient, not cause those who have coverage today to lose it.

Reform should emphasize both public and private sector cost containment.

Cost containment should seek to enhance competition and market forces, not supplant them.

There should be no significant savings in the Medicare program without expansions in coverage.

Steps should be taken to simplify administration of the health care system and to reduce fraud and abuse.

Better information should be available to private and public purchasers so that they can evaluate cost containment efforts.

CONSUMER PROTECTIONS

Businesses and individuals who have insurance today should be able to keep it, even if they get sick or change jobs.

- Without comprehensive insurance reforms, portability of coverage is not assured in all situations.

Businesses and individuals should be protected from unfair or discriminatory insurance practices.

- This principle leaves unspecified to whom reforms would apply (e.g., to individual purchasers as well as small businesses) as well as the extent of reforms.

Reforms should emphasize the principle of insurance: the broad spreading of risk.

- Small businesses and small busness associations want to preserve a self-insurance option.

- Proposals like MSAs would tend to discourage the broad pooling of risk.

Small businesses and individuals should have the same opportunities to obtain affordable coverage that larger businesses have.

- Providing greater purchasing opportunities to individual purchasers would require more comprehensive insurance reforms amd greater disruption.

Reforms should not restrict individuals from choosing their own physician or hospital.

- There is a tension between protecting choice of provider and encouraging the expansion of managed care. For example, any willing provider laws may undermine managed care.

- An alternative is to focus on providing individuals with the ability to select from among multiple health plans, including one that allows them the freedom to choose their own provider.

Individuals and businesses should have better information to make purchasing decisions.

- The business community will be concerned if the focus is particularly on health plan decision-making and potential abuses.

Reforms should encourage health plans and providers to improve quality of health care.

COVERAGE

Any reform legislation must provide for progress that puts us on the path towards universal coverage.

- This principle could be expanded to establish priorities for expansions in coverage (e.g., kids and those who lose their jobs).

- The business community (and, to some extent, organized labor) would be very concerned about giving states flexibility (e.g., ERISA waivers) to design their own health care programs to expand coverage.

Reform should maintain an adequate safety net for those who cannot obtain or afford private insurance.

- Some Medicaid proposals (e.g., providing block grants to states) could reduce coverage.

COST CONTAINMENT

Cost containment should make the delivery of health care more efficient, not cause those who have coverage today to lose it.

- Some Medicaid savings proposals could lead to reductions in coverage.

Reform should emphasize both public and private sector cost containment.

- There is no consensus around any type of active government role (e.g., tax cap, ratesetting) that is likely to achieve significant private sector cost containment.

Cost containment should seek to enhance competition and market forces, not supplant them.

- This principle could be expanded to include specific guidance on market structure issues (e.g., antitrust).

There should be no significant savings in the Medicare program without expansions in coverage.

Steps should be taken to simplify administration of the health care system and to reduce fraud and abuse.

- This principle could be expanded to include more specific guidance on issues such as malpractice and fraud and abuse.

Better information should be available to private and public purchasers so that they can evaluate cost containment efforts.

REPUBLICAN HEALTH INITIATIVE LIKELY MENU

1. Insurance Reform --Including Self-insured Expansions for Associations (ERISA changes)
2. Self-employed Tax Deduction
3. Tax Clarification for Long Term Care Private Insurance
4. State-based Reforms, Focusing on Medicaid Flexibility and/or Federalization
5. Tax Caps
6. MSAs
7. Medical Malpractice
8. Anti-trust Reforms
9. Fraud & Abuse
10. Simplification (Electronic Claims Processing/etc.)
11. Medicare Restructuring of HMOs/Medicare Select Policies
12. Product Liability
13. Investment in Public Health Initiatives
    (e.g., community health centers, rural health clinics, etc.)

DRAFT

CONSUMER PROTECTIONS

Businesses and individuals who have insurance today should be able to keep it, even if they get sick or change jobs.

Businesses and individuals should be protected from unfair or discriminatory insurance practices.

Reforms should emphasize the principle of insurance: the broad spreading of risk.

Small businesses and individuals should have the same opportunities to obtain affordable coverage that larger businesses have. (e.g. coops)

People should be able to choose their own physician or hospital. - we may not want to get into this. Same is providers v. big business
this is tied to ERISA.

Individuals and businesses should have better information to make ~~purchasing~~ health care decisions. (e.g. "report card"); require plans to disclose certain info

Reforms should encourage health plans and providers to ~~improve~~ maintain quality of health care.
- this issue could run counter to issue of choice.

COVERAGE

Any reform legislation must provide for progress that puts us on the path towards universal coverage.

Any interim expansions in coverage should be consistent with, and move us towards, universal coverage.

Note that some reforms under discussion may arguably make advancing towards U.C. more difficult, complicated

Reform should maintain an adequate safety net for those who cannot obtain or afford private insurance.
what do we mean by this

Reform should increase access to preventive care and improve the health of Americans.
with the goal of ing

AFFORDABILITY — this will go before Coverage section.

Cost containment should promote the efficient make the delivery of health care more efficient, not cut back on ~~cause those who have~~ coverage ~~today to lose it~~.

Our goal should be to control ~~reduce the growth of~~ both public and private sector health care costs.

Cost containment should seek to enhance competition and market forces, not supplant them.
— this: we can't do any willing provider and this

~~Any federal costs associated with reform should be fully financed, without increasing the deficit.~~ and as a minimum

Health care reform should not increase the deficit.

~~we want to~~

DRAFT

There should be no significant ~~savings~~ STET in the Medicare program without expansions in coverage.

Steps should be taken to simplify administration of the health care system and to reduce fraud and abuse. This is what the public thinks needs to be done.

Better information should be available to private and public purchasers so that they can evaluate cost containment efforts. This is "macroinformation" to help us evaluate what is happening in health care system.

- we need to put state flex principle in here somewhere

Chris decides to change this doc w/ to 5 or 6 principles

HEALTH CARE-RELATED TORT REFORM

THE PROBLEM

Although the evidence is mixed, many doctors and other members of the public believe that the vagaries of the jury system lead to unfair and inconsistent results in medical malpractice cases and that large jury awards drive up health care costs because doctors are forced to purchase expensive malpractice insurance policies and practice "defensive medicine." In addition, some argue that problems in the malpractice system cannot be addressed comprehensively unless products liability litigation is reformed as well.

MEDICAL MALPRACTICE: APPROACHES

HEALTH SECURITY ACT (S. 1757/ H.R. 3600)

Alternative dispute resolution

- Before claim can be brought, ADR (arbitration, mediation, and early offers of settlement) must have been utilized. Mandatory, non-binding.

Attorney's fees

- Contingency fees limited to maximum of 33.3% of the total amount recovered by judgment or settlement. States may impose lower limits.

Punitive damages; Cap on noneconomic damages

- No provisions.

Preemption

- Does not preempt states from imposing more restrictive legislation.

REPUBLICAN INITIATIVES

Republican initiatives in this area included the Dole, House Republican, Chafee, Rowland-Bilirakis, and Cooper-Grandy bills.

Alternative dispute resolution

- The Dole bill has no provision for ADR. Both the House Republican plan and the Cooper-Grandy plan provide for mandatory, non-binding ADR with appeals subject to English rule (in a contested ADR determination, the loser pays fees.) Chafee provides for the same, with mediation available at the request of any party. The Rowland-Bilirakis plan also includes mandatory, non-binding ADR.

Attorney's fees

- All of the bills except the Dole bill include a formula for determining attorneys fees: House Republican plan and Cooper-Grandy plan (25% of first $150,000; 10% of excess); Chafee plan (25% of award or settlement); Rowland-Bilirakis plan (25% of first $100,000; 20% of

next $150,000; 15% of next $250,000; 10% in excess of $500,000).

Punitive damages

- The Dole bill caps punitive damages at two times compensatory damages or $500,000, whichever is less. Other bills provide that a certain percentage of punitive damages be paid to the state (House Republican plan and Cooper-Grandy plan - 100%; Chafee plan - 75%). The Rowland-Bilirakis plan provides, as to manufacturers only, that 50% be paid to the state and that awards be capped at no more than two times the amount of all other damages.

Cap on noneconomic damages

- The Dole bill caps compensable noneconomic damages at $250,000 for the injured party and preempts state law in those states that have set such a cap at a higher figure. The House Republican plan, the Chafee plan, and the Rowland-Bilirakis plan all set a cap at $250,000. The Cooper-Grandy plan caps noneconomic damages at $250,000 but permits future development of alternative limits.

PRODUCTS LIABILITY: APPROACHES

Product liability issues may arise in the context of medical malpractice litigation because malpractice plaintiffs often name a drug or medical device manufacturer or supplier as one of the defendants.

The Health Security Act did not address products liability.

Contract with America

- One of the bills House Republicans intend to introduce within the first 100 days of the new Congress is the "Common Sense Legal Reforms Act."

- Important provisions include the award of attorney's fees to the prevailing party in civil cases brought in federal court under diversity jurisdiction, amending the Federal Rules of Evidence to provide that expert opinion is admissible only if a judge determines that it is based on "scientifically valid reasoning," and the abolition of strict liability for sellers.

- In addition, the bill provides that punitive damages may be awarded against sellers of a product only where there is clear and convincing evidence of malice and caps such damages at no more than the greater of three times the economic damages award or $250,000.

OPTIONS

Status quo: no Administration proposal.

Present last year's policy, making sure to communicate its strengths clearly.

Propose additional malpractice reforms that do not include damage caps.

Propose additional malpractice reforms, including damage caps.

Propose tort reforms that encompass malpractice and products liability reforms.

ANTITRUST

THE PROBLEM

Medical providers such as hospitals are interested in forming integrated health care delivery systems that will allow them to better compete in the evolving health care industry, particularly with managed care plans. The providers believe that their efforts to form such systems are constrained unduly by antitrust laws.

APPROACHES

ADMINISTRATION INITIATIVES

The Health Security Act repealed health insurers' exemption from McCarran-Ferguson Act.

DOJ/FTC Policy Statements

- In 1994, DOJ and FTC issued nine policy statements relating to the health care industry.
- The policy statements delineate safety zones that describe activities that will not be challenged by the agencies, barring extraordinary circumstances.
- Most activity that falls outside of a safety zone, if challenged, will be evaluated under rule of reason analysis.
- The agencies are committed to responding to most requests from the business community for advisory opinions (e.g., whether a proposed activity falls within the safety zone) within 90 days.

REPUBLICAN INITIATIVES

Republican initiatives in this area included Hatch/Archer (introduced in House and Senate); a revised Hatch/Archer incorporated in Dole; and the Canady amendment to H.R. 3600, which was reported out of the House Judiciary Committee.

Safe harbors

- The Republican bills created safe harbors, some of which were broader than the safety zones in the DOJ/FTC policy statements and some of which addressed topics that were not the subject of a policy statement.

- In Hatch/Archer and Canady, the safe harbors were established by statute. In Dole, the safe harbors were to be established through the formal administrative rulemaking process.

- The bills established procedures for the creation of additional safe harbors by the Attorney General.

Certificates of review

- The Hatch/Archer and Dole bills established procedures for the award of certificates of review to cooperative ventures by the Attorney General with the agreement of the Secretary of Health and Human Services.

- Cooperative ventures receiving a certificate of review would be exempt from antitrust laws.

Notification procedures

- Under Hatch/Archer and Dole, cooperative ventures that filed with the Attorney General would receive guaranteed rule of reason analysis of their activities and detrebling of antitrust damages awarded against them.

OPTIONS

Present last year's proposal on this subject.

Continue current administrative approach and do not propose legislation.

Propose more extensive legislation.

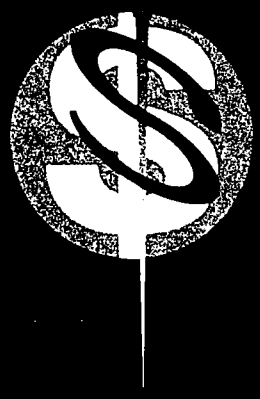
Council on the Economic Impact of Health Care Reform

#3
November 1994

MARKET CONCENTRATION, ANTITRUST, AND PUBLIC POLICY IN THE HEALTH CARE INDUSTRY

Prepared by:

David Shactman



DRAFT

MARKET CONCENTRATION, ANTITRUST, AND PUBLIC POLICY IN THE HEALTH CARE INDUSTRY

Prepared for:

THE COUNCIL ON THE ECONOMIC IMPACT OF HEALTH CARE REFORM

November 28, 1994

Washington, D.C.

Prepared By:

David Shactman

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The American health care system is undergoing a period of prodigious change. Even without national health care reform, the emergence of competition through managed care, selective contracting, and vertically integrated health networks is changing the traditional structure of health care markets. Managed care plans, now insuring nearly 50 million Americans, have been effective in negotiating discounted prices with hospitals and physicians, and have been a contributing factor in reducing the rate of increase in health care spending.

Balanced against them, hospitals and physicians have engaged in unprecedented consolidation through mergers, acquisitions, and joint ventures. Such consolidation offers the potential for increased efficiency and enhances the ability of providers to bargain more effectively with managed care plans.

As both forces have sought to increase their market strength, their activities have come under the purview of antitrust. The extent of market consolidation and the future structure and control of the health care system could be determined by antitrust enforcement policies. The purpose of this paper is to examine the consolidation now occurring in the health care industry and to identify pertinent issues of concern to members of the health care community, public policy makers and the general public.

The first section of the study presents a brief historical perspective of the economic forces that have prompted market consolidation and the government response through antitrust enforcement. The central questions of the study are then posed:

- In a market with competitive health networks, what is the most efficient system in terms of cost, access, and quality? Is it one structured through strong antitrust enforcement challenging consolidation and integration, or is it one structured through lenient antitrust enforcement, allowing potential efficiencies through collaborative mergers and acquisitions? What policies result in a competitive balance of institutional forces?

- What are the health policy issues that inform the above questions, and are the antitrust divisions of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) the proper decision making bodies to analyze those issues?

- Should our health care system be structured by a system of competing managed care networks regardless of antitrust policy?

The second section of the study presents a summary of the recent literature regarding the relative efficiencies of concentrated and competitive health markets. Studies are reviewed that compare the costs of health care in California under selective contracting with less competitive markets.

The final section reviews the legal statutes that are the basis for antitrust enforcement. It then presents an overview of the methodology of merger analysis and the current enforcement policy statements of the FTC and the DOJ, a detailed summary of which appears in the appendix. The final section also presents a discussion of pertinent federal and state legislative initiatives.

Historical Perspective

Since 1960 there has been explosive growth in the cost of health care in the United States. Fueled by government programs, increases in technology, and the availability of health insurance, health expenditures increased from 5% of our gross domestic product (GDP) in 1960, to over 14% today.[1] Beginning in the 1970's, federal and state governments made numerous attempts to reduce the growth in health spending, but met with little success. Beginning in the mid 1980's, with the introduction of Medicare prospective payment, policy makers succeeded in reducing the rate of increase in inpatient hospital services. However, total health expenditures continued to increase faster than the economy as a whole.

Hospitals, partly encouraged by government programs such as Hill Burton, Medicare, and Medicaid had been building capacity for decades. Beginning in the 1980s however, the confluence of several factors such as prospective payment, changes in technology, and patterns of reimbursement, left hospitals with excess acute care capacity. Concurrently, hospitals began to face other financial pressures. Reimbursement rates from Medicare and Medicaid often were below the levels necessary to cover the average costs incurred by hospitals. Hospitals also assumed a growing burden of providing care to the uninsured. In addition, managed care plans began to negotiate aggressively to procure discounts from hospitals and other providers.

Hospitals have thus far been able to maintain their financial margins by increasing outpatient revenues and by raising prices to the private sector. However, all of the above factors make their future ability to do so uncertain. Facing accumulating pressures in a new competitive environment, hospitals have sought collaborative arrangements through mergers, acquisitions, and joint ventures. Their goals have been to increase efficiency by reducing excess capacity and duplication of services, and to maintain operating margins by increasing their bargaining power with managed care plans.

Antitrust Laws

Mergers and acquisitions enabled hospitals to increase their market power and gave some the potential to raise prices. As a result, the FTC and the DOJ challenged several hospital mergers in the 1980s and established their jurisdiction over both for-profit and non-profit

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[1]Prospective Payment Assessment Commission, Medicare and the American Health Care System, Report to the Congress, June 1994.

health merger transactions. The hospital community and the American Hospital Association (AHA) feared strong government enforcement and claimed that the regulatory agencies were having a "chilling effect," preventing efficient collaborations among providers.

The government defended its enforcement policies, pointing out that out of 397 mergers from fiscal 1981 through fiscal 1993 only 15, or 4% of mergers, were either challenged, withdrawn, or resulted in consent decrees. The FTC and the DOJ issued "Horizontal Merger Guidelines" and "Antitrust Enforcement Policy Statements" to clarify their policies and to stave off efforts to legislate limitations on antitrust enforcement.

Hospitals, physicians and their supporters lobbied federal and state governments for legislation that would grant antitrust exemptions and additional safe harbors to collaborative activities by providers. Insurance companies, managed care plans and their supporters opposed all such legislative initiatives and lobbied for strong enforcement of antitrust. Under lobbying pressure from both forces, Congressional hearings were held and bills were introduced that provided antitrust protection for providers. However, none of those bills was enacted in the 103rd Congress. Twenty four states enacted programs of "State Action Immunity" to provide antitrust exemptions to providers that undertook collaborative actions pursuant to a program of state regulation. Thus far, federal and state actions have primarily been the result of stakeholder pressure rather than independent study and research.

Issues

The basic issues in this discussion concern both efficiency (in terms of cost, access, and quality) and a balance of market power. Insurance companies and managed care plans believe that efficiency will be maximized by competitive markets that will result from strong enforcement of antitrust. They warn that lenient antitrust will allow providers to acquire extensive market power, and that providers will use that power to raise prices and negate the advantages of competition.

Hospitals and physicians argue that only through collaborative actions (such as mergers, acquisitions and joint ventures), will they be able to increase efficiency by reducing excess capacity and duplication of services. They also claim that they need countervailing market power to "level the playing field" and negotiate effectively with insurance companies and managed care plans.

Both managed care plans and hospitals have been engaged in vertical integration in an attempt to control their own health networks. Insurance plans have been contracting with or acquiring hospitals and physician groups, and hospitals have been contracting with or acquiring physician groups and insurance plans. Combining the financing and delivery of care may reduce competition, but it has not been the primary focus of antitrust. The creation of large, vertically integrated networks changes the structure and financial incentives of our traditional heath institutions. What will be the nature of these institutions and will they maintain a mission to serve their communities?

Some analysts believe that competitive managed care systems will not produce the most efficient health markets. Because of particular aspects of health markets such as insurance and large government purchasers, they argue that some amount of regulation is needed to make markets work and to provide an equitable distribution of health services. Other analysts question whether we should depend on managed care to be the basis of our health system. They question whether managed care provides real production efficiencies and, if it does, who will be the beneficiary of those savings.

The issues involved in these decisions involve access and quality of care as well as market efficiency and cost. Competitive markets will reduce excess capacity through hospital closures. Opponents of strong antitrust enforcement argue that some closures may occur in areas in which hospitals provide essential services to their communities. They believe that hospitals that support charitable missions and that serve a disproportionate share of the poor and uninsured will be the least able to compete. Hospitals argue that if they are denied the economic benefits of collaboration, they will not have the financial strength to support their charitable missions. Furthermore, they argue, that financially weak hospitals will not be able to sustain a high quality of care or maintain investments in new technology.

Proponents of strong antitrust policy believe that services will be allocated most efficiently by competition. They argue that allowing hospitals to consolidate will result in higher prices and less affordability to consumers. They argue that if services are allocated, monopoly practices will develop in those product markets, and both cost and quality of care will be adversely affected.

Conclusion

Profound changes are occurring in our health care system. Decisions regarding mergers, acquisitions and joint ventures that could transform the structure and control of the health industry, are being decided in corporate board rooms and antitrust regulatory agencies. Legislative remedies are being proposed by stakeholders and lobbyists. Authoritative and independent sources of information are needed to raise the visibility of these issues and to provide research that can be the basis for sound public policy.

1.0 ISSUES RAISED BY MARKET CONSOLIDATION AND ANTITRUST

1.1 INTRODUCTION

The purpose of this paper is to examine the consolidation now occurring in the health care industry and to encourage an open and informed discussion regarding the public policy response. The American health care system is undergoing a period of enormous change, even without national health care reform. The growth of managed care, the unprecedented numbers of mergers and acquisitions, and the creation of vertically integrated health networks are transforming the traditional structure of American health care markets.

Given these changing circumstances, there is a need to examine the following questions: Is the present antitrust policy appropriate, allowing the structural changes necessary to improve the cost, access, and quality of our health care system? Are enforcement policies too strong, impeding collaborative efforts within the industry to increase efficiency and to allow competitive parity among insurers, hospitals and physicians? Are enforcement policies too lenient, foreclosing the advantages of price competition and permitting firms to acquire market power?

The future structure of our health delivery system is now being strongly influenced by the antitrust departments of the Federal Trade Commission (FTC) and the Department of Justice (DOJ). Their enforcement policies could determine the extent of market consolidation and the nature and control of our health care system. Complex issues of health and social policy are involved that can affect the lives of all Americans. An informed, open debate is warranted in order to ensure the formulation of sound public policy.

This study seeks to encourage such a debate by undertaking the following tasks:

- Identifying the issues raised by market consolidation and antitrust
- Summarizing the economic issues that are the basis of these activities
- Providing pertinent information regarding antitrust law and how it is applied to the health care industry

In that regard, the paper is organized into the following three sections: Section one provides a historical perspective to the market changes that are now taking place. It then identifies the key issues raised by market consolidation and antitrust. Section 2 presents a summary of the recent literature regarding the relative economic cost of competitive and concentrated health markets. Section 3 provides a review of antitrust law and its application to the health industry. It includes descriptions of federal statutes, analytical guidelines, policy statements, state action immunity, and recent legislative initiatives.

The focus of this study is on hospital mergers and acquisitions. Other antitrust issues are raised by the growth of competitive health networks including questions of health care access as a result of exclusion from provider panels. The Council intends to address those issues in the near future.

1.2 HISTORICAL PERSPECTIVE

1.2.1 Public Policy to Build Capacity

For over two decades following the second world war, federal government policy encouraged expansion in the health care industry. The Hill-Burton Act in 1946 provided federal funding for the construction and renovation of hospitals and became a prototype for federal involvement in health care.[2] Federal programs to support medical education and research were enacted in the 50's and 60's and culminated in the enactment of Medicare and Medicaid in 1965. Medicare provided hospitals cost-based reimbursement for services performed and for capital expenditures and thereby encouraged increased utilization. Advancements in technology and the availability of insurance, in addition to government programs, contributed to rapid growth in the health sector. Since 1960, total health spending as a percent of Gross Domestic Product (GDP) grew from 5% to 14%. Figure 1 shows that the portion of health spending paid by the government increased from 24.7% to 43.9% between 1965 and 1991.

Figure 1. National Health Spending, by Source of Payment, 1965 and 1991 (In Percent)

Payment Source	1965	1991
Medicare	0.0%	16.3%
Medicaid	0.0	13.4
Other government[a]	24.7	14.2
Private	75.3	56.1
Health insurance	24.0	32.5
Out of pocket	45.7	19.2
Other[b]	5.5	4.4

[a] Includes Department of Defense, Department of Veterans Affairs, Public Health Service, Federal research, Federal and state and local workers' compensation, subsidies to hospitals, and public health activities.

[b] Includes industrial in-plant health services, provider non-patient revenues, private donations, and privately financed construction.

SOURCE: Health Care Financing Administration, Office of the Actuary, Prospective Payment Assessment Commission, supra #1.

[2]Litman, Theodor J. and Robins, Leonard S., *Health Politics and Policy*, John Wiley and Sons, Inc.. p. 18, 1984.

1.2.2 Shift in Public Policy and Causes of Over-Capacity

The explosive growth of the health care sector and the expense of funding federal health policies soon became a drain on federal and state budgets. Public policy shifted from encouraging expansion to controlling cost. Following the recession of 1970, government at both the federal and state levels instituted various policies to restrain the growth in health spending. Reform of Medicare and Medicaid reimbursements, regulation of supply of services, utilization review, and encouragement of the growth of HMO's were all attempted.[3] At least until recently such efforts achieved limited success.

Beginning in the mid 1980's, however, the long term spending trend for inpatient hospital care began to improve. Hospital use rates and length of stay have declined since the 1970's, particularly after the introduction of Medicare prospective payment. Figure 2 shows that discharges per thousand declined from 156.9 in 1979 to 124.1 in 1991. Average length of stay decreased from 7.1 to 6.4 days over the same period.

Figure 2. Short-Stay Hospital Discharges and Average Length of Stay, Selected Years

	Discharges Per 1,000 Population			Average Length of Stay (In Days)		
Age	1979	1984	1991	1979	1984	1991
Total	156.9	148.2	124.1	7.1	6.5	6.4
Under 15	70.8	62.0	45.3	4.3	4.5	4.8
15-44	151.8	132.2	99.3	5.2	4.9	4.6
45-64	192.4	183.3	132.2	8.2	7.2	6.5
65+	361.5	400.4	340.3	10.8	8.9	8.6

SOURCE: National Center for Health Statistics, *Health, United States 1986*; and Edmund Graves, "1991 Summary: National Hospital Discharge Survey," *Advance Data*, National Center for Health Statistics, No. 227, March 3, 1993, Prospective Payment Assessment Commission, supra #1.

Several major factors can be identified that altered incentives within the industry and caused a decline in the demand for inpatient services:

1. Medicare prospective payment set fixed prices for inpatient services, changing cost-based incentives, resulting in a decrease in average length of stay and a shift to outpatient services.

[3]Prospective Payment Assessment Commission, Supra # 1

2. Advancements in technology, particularly in micro-surgery techniques, allowed the treatment of patients in less restrictive clinical settings.

3. Managed care and selective contracting helped restrain rates paid to providers and employed extensive utilization review of provider services.

Figure 3 illustrates that the number of hospital beds also declined during the same period. The decline in beds, however, was not sufficient to compensate for the reduction in demand for inpatient services and, as figure 3 illustrates, occupancy rates fell from 75.9% in 1980 to 61.4% in 1993.

FIGURE 3. Change in Average Hospital Occupancy Rate and Number of Beds, 1980-1993

Year	Occupancy Rate	Percent Change	Number of Beds*	Percent Change
1980	75.9%	1.9%	970,500	1.2%
1981	75.8	-0.1	986,900	1.7
1982	74.6	-1.6	997,700	1.1
1983	72.2	-3.2	1,003,700	0.6
1984	66.6	-7.8	992,600	-1.1
1985	63.6	-4.5	974,600	-1.8
1986	63.4	-0.4	963,100	-1.2
1987	64.1	1.1	954,500	-0.9
1988	64.5	0.6	942,300	-1.3
1989	64.9	0.6	930,100	-1.3
1990	64.5	-0.6	921,400	-0.9
1991	63.5	-1.6	911,800	-1.0
1992	62.1	-2.2	907,700	-0.5
1993	61.4	-1.1	901,700	-0.7
Averages				
1980-1983	74.6	-0.8	989,700	1.1
1984-1993	63.8	-1.6	936,900	-1.1

*
Rounded to nearest 100.

SOURCE: American Hospital Association National Hospital Panel Survey, Prospective Payment Assessment Commission, supra #1.

1.2.3 Response to Over-Capacity by Hospitals

The hospital industry had to contend with numerous pressures, including over-capacity of inpatient beds, declining census, unprofitable levels of reimbursement from Medicare and

Medicaid and, in many cases, the obligation to provide free care to the uninsured. In addition, the emergence of competition and the growth of managed care forced hospitals to negotiate discounted rates with many private health insurance plans.

Despite these pressures, however, hospitals were able to maintain their financial operating margins. They did so by shifting services to and increasing utilization of outpatient departments, shifting cost to the private sector, and consolidating their services and facilities through mergers, acquisitions, and joint ventures.

Increases in Outpatient Services

Figure 4 shows the relative shift in revenues from inpatient to outpatient services.

Figure 4. Change in Hospital Revenue and Proportion of Revenue, by Source, 1980-1993 (In Percent)

	Change in Revenue				
	Inpatient Revenue Per	Outpatient Revenue Per	Proportion of Revenue		
Year	Admission	Visit	Inpatient	Outpatient	Other
1980	14.5%	15.8%	83.2%	12.5%	4.3%
1981	17.3	19.2	82.7	12.7	4.5
1982	16.2	16.8	82.7	12.9	4.4
1983	10.4	11.5	82.4	13.4	4.2
1984	8.6	12.4	81.3	14.4	4.3
1985	8.9	13.2	79.3	16.1	4.6
1986	8.5	8.3	78.0	17.5	4.5
1987	8.9	10.7	76.8	18.6	4.6
1988	8.5	11.4	75.2	20.0	4.8
1989	9.4	11.5	74.0	21.1	4.9
1990	9.2	11.7	72.5	22.5	5.0
1991	9.3	12.0	71.1	24.0	4.8
1992	8.2	8.6	69.8	25.4	4.9
1993	4.9	3.8	68.9	26.2	5.0
Averages					
1980-1983	14.6	15.8			
1984-1993	8.4	10.3			

SOURCE: American Hospital Association National Hospital Panel Survey, Prospective Payment Assessment Commission, supra #1.

In 1984, the proportion of total hospital revenues from inpatient and outpatient services accounted for 81.3% and 14.4% respectively. By 1993 that had changed to 68.9% and

26.2%. Changes in technology, utilization review by payers, and more favorable reimbursement rates were the chief reasons for these shifts in revenues.

Shifting of Cost to the Private Sector

It is estimated that the cost of treating Medicare patients exceeds reimbursement rates by approximately 12%. Figure 5 shows that in 1992 hospitals lost nearly $11 billion treating Medicare patients, $3 billion treating Medicaid patients, and over $12 billion providing uncompensated care.

Figure 5. Gains and Losses on Payment for Hospital Services, by Source, 1992

Payment Source	Payment to Cost Ratio	Gain or Loss (In Billions)
Below-cost payment		
Medicare	0.89	$ -10.8
Medicaid	0.91	-3.0
Other government	0.98	-0.1
Uncompensated care*	0.19	-12.1
Total		-26.0
Above-cost payment		
Private insurers	1.31	29.0
Operating subsidies above uncompensated care*		0.5
Total		29.5

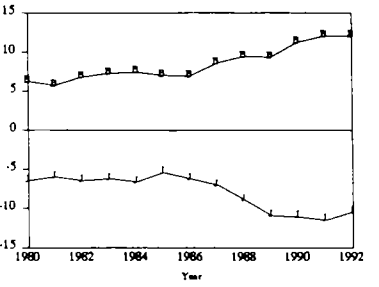
Note: Due to reporting inconsistencies related to Medicaid disproportionate share payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992.

* Operating subsidies from state and local governments are counted as payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Additional subsidies above this level are shown as a separate revenue source.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals, Prospective Payment Assessment Commission, supra #1.

However, they were able to more than compensate for these losses by increasing their rates to privately insured patients. Figure 6 presents a visual representation of this situation.

Figure 6. Total Losses and Total Gains as a Percentage of Hospital Costs, 1980-1992



Note. Gains and losses are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Excludes non-patient care income. Due to inconsistencies related to Medicaid disproportionate share hospital payments and provider specific taxes, there are significant margins of error for the numbers related to all payers in 1992.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

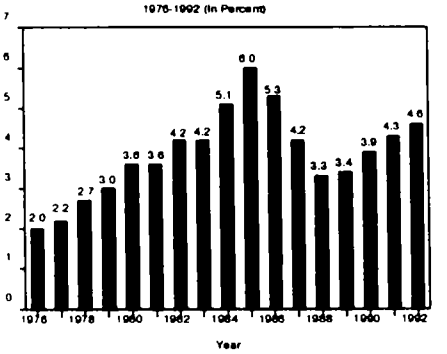
The overall effect on total margins is illustrated in figure 7. With the exception of the initial rise and fall of margins following the introduction of prospective payment, the hospital industry has been able to maintain and even increase operating margins despite the pressures enumerated above.

Consolidation of Services and Facilities through Mergers, Acquisitions and Joint Ventures

Hospitals and physicians engaged in an unprecedented amount of collaborative activity such as mergers, acquisitions, and joint ventures. These actions give them the potential to increase efficiency by decreasing excess capacity, reducing duplication of services, and sharing the capital cost of high-tech and expensive medical equipment. In addition, gaining increased power in local markets provides the potential to negotiate better rates with managed care plans.

Figure 8 on the following page summarizes the merger activity of hospitals and shows that from a low of 9 mergers in fiscal 1982, there were 48 mergers in 1993.

Figure 7. Aggregate Total Margin 1976-1992 (In Percent)



SOURCE: American Hospital Association Annual Survey of Hospitals.

FIGURE 8

Acute Care Hospital Merger Enforcement Actions Taken by the FTC and the DOJ

Year	Hart-Scott-Rodino filings	Preliminary Investigations	Second Requests For Information	Challenged Settled or Withdrawn
1981	15	5	1	0
1982	9	2	1	1
1983	20	4	1	1
1984	29	4	1	0
1985	32	2	1	1
1986	27	3	0	0
1987	30	5	4	2
1988	43	5	1	1
1989	35	3	1	1
1990	36	9	8	1
1991	31	4	2	2
1992	42	9	3	1
1993	48	13	4	4
TOTAL	397	68	28	15

Source: General Accounting Office, *Federal and State Antitrust Actions Concerning the Health Care Industry (August, 1994)*

1.2.4 Reaction by the Government Antitrust Agencies

The Department of Justice and the Federal Trade Commission responded to the increase in collaborative activity among providers by enforcing the federal antitrust laws. Proceeding primarily under Section 7 of the Clayton Act and Section 1 of the Sherman Act, the government established its jurisdiction in cases involving both profit and non-profit institutions in the health care industry.[4] Several prominent cases in the late 1980's[5] caused many, particularly the American Hospital Association (AHA), to fear the specter of stringent antitrust enforcement. Frequent complaints were made that government policy was producing a "chilling effect"[6] and was preventing, either by court challenge or by the threat of expensive litigation, collaborations within the industry that were needed to increase efficiency and to achieve needed consolidation of facilities.

The FTC and the DOJ defended their enforcement policies, pointing out that they have challenged few mergers and that merger activity has continued to increase. Figure 8, on the previous page, presented a summary of antitrust merger enforcement from fiscal 1981 through fiscal 1993. Of 397 pre-merger notifications that were filed during this period, 15 (4%) were either challenged, withdrawn or resulted in consent decrees. Hospitals, physicians, and their supporters lobbied Congress to enact protective legislation. Insurance companies, managed care plans, and their supporters opposed any legislation that would weaken antitrust enforcement. The FTC and the DOJ issued "Horizontal Merger Guidelines" in 1992 and "Antitrust Enforcement Policy Statements" in 1993 and 1994 in an effort to clarify their policies, reduce uncertainty, and to strengthen their opposition to protective legislative initiatives.

Under pressure from both providers and insurers, the 103rd Congress held several hearings to discuss the issues of hospital mergers and antitrust. A number of bills were filed that would have instituted protective measures for hospitals and other providers such as antitrust exemptions, safe harbors, and limitations of damages. Congress did not act on any of these bills, but some provisions will probably be proposed again in the next Congressional session.

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[4] Goldfarb V. Virginia State Bar, 421 U.S. 773 (1975). Hospital Building Company V. Trustees of Rex Hospital, 425, U.S. 738 (1976), U.S. V. Carilion Health System, et. al., 707 F. Supp. 840 (W.D.Va. 1989). U.S. V. Rockford Memorial Corp., et. al., 1989-1 Trade Cas. (CCH) p. 68,462, (N.D. Ill. 1989).

[5]See U.S. V. Carilion Health Systems, et. al., supra #4; U.S. V. Rockford Memorial Corp., supra #4; FTC V. University Health Inc., 1991-1 Trade Cas. (CCH) p. 69, 444 at 65, 839 (S.D. Ga. Apr. 3), vacated, 938 F. 2d 1206 (11th Cir. 191); Ukiah Valley Medical Center V. FTC, 1990-1, CCH p. 68, 916 (N.D. Cal 1990).

[6]Hatch, Orrin, testimony before the Subcommittee on Antitrust, Monopolies and Business Rights of the Committee on the Judiciary, U.S. Senate, 103rd Congress (3/23/93)

The most relevant initiative, entitled the "Hatch-Thurmond Health Care Antitrust Improvements Legislation," is reviewed in Section 3.7.

The states, under similar political pressure, also sought to provide protection to collaborating hospitals and physicians. Twenty four states enacted provisions under the "Doctrine of State Action Immunity" (see Section 3.5), which allows the states to provide antitrust exemptions to organizations undertaking collaborative activities pursuant to a state regulatory plan.

Stakeholders from various parts of the health industry, all having a substantial financial interest, have lobbied the government for policies that support their partisan and pecuniary interests. Reliable, independent research is needed to advise policy makers on the economic and health policy implications of antitrust enforcement policy. The problem was summed up by Senator Metzenbaum in hearings before the Senate Finance Committee on May 7, 1993.

> "The whole question that we have before us is, how do we bring down the cost of operating our hospitals, and our medical facilities, and our drug costs? Do we do it by stronger enforcement of our antitrust laws or by weakening our antitrust laws?"

1.3 THE PRIMARY ISSUES RAISED BY MARKET CONSOLIDATION AND ANTITRUST

In the mid-1980s, competition emerged as a potential instrument to reduce the growth in health care spending. Managed care networks, selectively negotiating contracts with hospitals and physicians, bargained aggressively to achieve discounted rates in return for membership in their provider panels. Enrollment in HMOs dramatically increased, surpassing 19% of the total population in 1993 and covering nearly 49 million Americans.[7] As enrollments increased, HMOs sought to extend their markets. They expanded horizontally, offering a variety of managed care options, and merged with and acquired other plans. They also expanded vertically by forming integrated health networks and acquiring or contracting (sometimes on an exclusive basis) with hospitals, outpatient clinics, specialty centers, and provider groups.

Proponents of managed care believe that this new competitive environment will force efficiency into the health care system. In other industries, competition has been our traditional means of allocating resources. Proponents believe that competition among health networks will lower cost and reduce excess capacity, and that the most inefficient organizations will be weeded out of the marketplace.

Hospitals have had to adjust to this new competitive environment at a time when they face financial pressure from a number of sources. Although they have maintained their financial

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[7]Summary of a report by Marion Merrell Dow, Inc., *Medical Benefits*, 10/30/94.

margins, at least temporarily, they have had to contend with overcapacity of acute care services and losses incurred from the treatment of Medicare and Medicaid patients and the uninsured. They have done so by increasing outpatient revenue and by charging higher prices to their private payers. The emergence of competition and the necessity to contract selectively with insurance companies and managed care networks, however, has required hospitals to negotiate discounted rates in order to compete for the patients who are members of these plans. This has made their future ability to shift cost uncertain.

Hospitals and other providers, feeling the twin pressures to become more efficient and to maintain their market share, have sought out collaborative arrangements through mergers, acquisitions, and joint ventures. Providers, responding to marketplace pressures have also sought to expand vertically by acquiring or contracting (sometimes on an exclusive basis) with insurance plans and provider groups. Supporters of hospital mergers argue that these collaborative measures are necessary for hospitals to become more efficient by reducing their excess capacity and duplication of services, allocating complex procedures to individual specialty centers, and sharing the cost and utilization of high tech, expensive equipment. Although such consolidation offers the potential for a more efficient delivery system, it also increases the market power of such providers and could enable them to bargain for higher rates.

Hence, competition has been driven by insurance companies and managed care plans on the one hand and consolidation has been the response of hospitals and physicians on the other. Each side has a valid argument for economic efficiency, but also acquires the possibility of significantly increasing market power. The primary issues can be summarized as follows:

- What policies will produce the most efficient system in terms of cost, access and quality? Strong antitrust enforcement that weeds out excess capacity and duplication of services by competition and survival of the fittest, or more lenient enforcement that allows hospitals to reduce excess capacity and allocate high tech and expensive services by collaborative arrangements such as mergers and acquisitions.

- What policies will provide a level, competitive playing field? Hospitals and physicians argue that strong antitrust enforcement will lead to the dominance of insurance companies and managed care organizations. They argue that unless they can collaborate and acquire countervailing power, the system will be left with weak provider institutions that are forced to accept low payments to survive. Furthermore, they argue that strong insurers could use their bargaining leverage to increase operating margins and distribute the resulting profits to stockholders. Insurance companies and managed care organizations argue that lenient enforcement will give market power to large providers. They argue that this will result in higher prices to consumers and could eradicate the advantages of competitive markets.

- An equally significant issue is whether competitive systems of managed care, regardless of antitrust, are the optimal systems in terms of cost, access and quality? Some analysts believe that ultimately, competition will not work in health markets (see section 2.2) and that regulation needs to be part of the solution. Still others doubt the efficacy of managed care and question whether it can increase productivity and decrease price over the long term.

  Consumer advocates are wary of issues that arise from either strong or lenient enforcement of antitrust. They are concerned with access problems as a result of strong enforcement and the potential failure of weak community hospitals (discussed in the next section). They also fear lenient antitrust that could result in large hospital systems acquiring market power and raising prices.

The unprecedented number of mergers and acquisitions and the struggle between these forces to increase their market share may well define the future structure of the American health care system. The antitrust departments of the FTC and the DOJ have become the arbiters of this struggle. Their enforcement policies could determine the extent of these mergers and acquisitions and the kind of health system that emerges. In the absence of a national policy about who controls our health delivery system, these regulatory agencies are being asked to decide critical issues of public policy.

These issues involve much more than market efficiency and market power. There are numerous issues of equity, access, and quality such as: the ability of competitive systems to allocate medical services equitably across society; the closure of hospitals in rural or under-served communities; the difficulty of inner city hospitals to compete because they service poorer populations; the difference in incentives between for-profit and non-profit hospital systems; the incentives for quality and technological advancement; and the funding for the charitable and educational missions of our traditional health institutions.

These issues are identified in the next three sections. Many of these problems are interdependent, but in order to include all issues in an organized fashion they are presented as follows:

- Issues Raised by Strong Enforcement of the Antitrust Laws
- Issues Raised by Lenient Enforcement of the Antitrust Laws
- Issues Raised by Opponents of Competitive Health Systems and Managed Care

1.3.1 Issues Raised by Strong Enforcement of Antitrust Laws

Allocation of Resources

Classical economic theory teaches us that competitive markets provide the most efficient

allocation of resources. However, there is disagreement whether health markets follow this paradigm. The demand for hospital services typically comes from health plans or physicians and not from consumers. Therefore, hospitals tend to supply services that attract health plans and doctors, such as high-tech equipment, a full range of services, and attractive physical plant. This is commonly referred to as competition by quality rather than by cost. Although selective contracting has increased the relative importance of price, non-price competition is still an important factor. At issue is whether competition will weed out the excess capacity and duplication of services that now exist in the industry. Hospitals argue that collaborative efforts are necessary to accomplish these tasks. Proponents of strong antitrust enforcement believe that the marketplace can accomplish these tasks more efficiently and without the risk of firms acquiring market power.

Allocation of medical services is a related issue. Studies have shown that outcomes from complex procedures are better in hospitals that perform them more frequently (see section 2.5.1). Some health researchers advocate regional specialization for complex procedures. For example, one hospital might perform all cardiac surgery in an area, while a competitor might perform all complex neo-natal care. However, allocation of services is a violation of the antitrust laws. Hospitals argue that strong antitrust enforcement prevents this type of collaboration and could lead to duplication of services, low utilization, and poor outcomes. This could have a particularly strong impact in small or rural markets, in which the demand for a particular service may not be large enough to fully utilize more than one facility.

Rural vs. Urban or Small vs. Large Markets

Rural or small markets with few hospitals may not be able to support a sufficient level of competition to reduce excess capacity and duplication of services. For example, two or three hospitals might need the clinical benefits of an MRI. However, the demand in a small community may be such that each can only utilize this equipment less than half of the time. Some analysts believe that collaboration is necessary to make these markets more efficient, but it is prevented by strong antitrust enforcement. Legislation has been proposed that provides for exemptions and safe harbors for collaborative activity in small markets. Proponents of strong antitrust have argued that granting these exemptions forecloses the potential for competition which is just beginning to enter these markets.

Closures of Hospitals

Strong enforcement of antitrust and, hence, "tough" competition will cause the closure of some hospitals. There is concern that some of the hospitals that close might be those that provide essential access to care in their resident communities. Furthermore, it is a concern that hospitals serving poorer populations and providing large amounts of uncompensated care, particularly inner city hospitals, may be at a competitive disadvantage and may be the most apt to fail in a competitive market. This is a crucial issue for urban community hospitals and consumer advocates.

Existence of Non-Profit Institutions

Concern has been raised that strong enforcement of antitrust laws may cause the decline of non-profit hospitals. The two major reasons for hospitals to merge, increased efficiency and stronger bargaining positions with payers, increase the competitive viability of hospitals. Without the opportunity to acquire countervailing power, hospitals fear increased financial pressure. This may be particularly true of non-profit hospitals, which have to support charitable missions and which often serve populations that consume higher than average amounts of health services.

Charitable and Educational Missions

Non-profit hospitals have traditionally provided charitable and educational services to the communities that they serve. The economic pressures mentioned heretofore and the reduced ability to shift costs leaves funding for these missions in doubt. Figures 5 and 6 in Section 1.2.3 showed the amount that hospitals shift cost to private payers to provide care under public programs. Hospitals argue that absent the ability to collaborate, they may not have adequate funds in the future to support these missions.

Incentives for Quality Improvement and Investment in Technology

The economic pressures referred to above also raise concern about funding to maintain quality and to invest in new technology. Supporters of lenient antitrust argue that if collaboration is not permitted, weakened and poorer quality provider institutions will result.

1.3.2 Issues Raised by Lenient Enforcement of Antitrust Laws

Market Power

The primary concern regarding lenient antitrust enforcement is that providers will acquire market power, which they will use to raise prices. Studies of the California market, reviewed in Section 2.2, show that health markets tend to be concentrated by nature, and that competition is fragile. Small changes in the number of competitors can materially change the bargaining power of providers in their negotiations with payers. Proponents of strong antitrust enforcement argue that if providers are allowed to collaborate and acquire market power, the advantages of competition will be nullified.

Economies of Scale

The antitrust agencies determine the value of a merger by analyzing whether the efficiencies produced outweigh the potential anticompetitive effects.[8] One of the most significant factors

[8] A detailed discussion of merger guidelines is presented in Appendix A

cited in producing efficiencies is economies of scale. However, current literature[9] indicates that economies of scale tend to be exhausted at a hospital size of approximately 200 beds. Proponents of strong antitrust enforcement argue that since most mergers of antitrust concern involve hospitals larger than 200 beds, the arguments for potential efficiency are questionable and that market power may be the primary motivation.

Oligopoly

Lenient antitrust enforcement will result in increased consolidation and may lead to oligopolistic markets. If the proposed Columbia/HCA-Healthtrust and NME-AMI mergers are completed as expected this winter, those two chains will control 61% of the 122,000 for-profit beds in the United States.[10] The point at which markets become oligopolistic varies among industries, and is an important issue in assessing the future economic implications of market consolidation.

The Structure of Vertically Integrated Markets

Lenient enforcement of antitrust laws will permit ongoing vertical integration of health markets. Competition will occur among health plans rather than at the consumer/insurance company, consumer/hospital or consumer/physician level. Integrated plans will provide both the financing and the delivery of care. Many health markets are likely to evolve similar to those in Worcester, MA or in Minneapolis/St. Paul as shown in figures 9 and 10. In Worcester, there were seven independent hospitals in 1979. By 1992, there were four hospitals belonging to three networks. They served 80% of the population and there were no other independent hospitals. In Minneapolis/St. Paul there were 24 independent hospitals in 1981. By 1992, there were 19 hospitals belonging to three health networks. Those networks served 71% of the population and there were 5 other independent hospitals. The trend is for two or three huge integrated health networks to acquire or merge with nearly all of the independent hospitals and to service an entire geographical region.

This structure changes the nature of our traditional institutions. Both the capital needs to assemble these systems and the flow of capital they generate provide a different kind of health institution and a different set of incentives. These systems are more likely to be for-profit. Rather than being governed by a board of directors from the local community, they are more likely to be run by MBAs whose attention is focused on financial markets. Their size in terms of capital and employment is likely to make them a political force within their region. Whether or not this is preferable to our tradition of non-profit hospitals which provide care for the members of their community is a question worthy of consideration.

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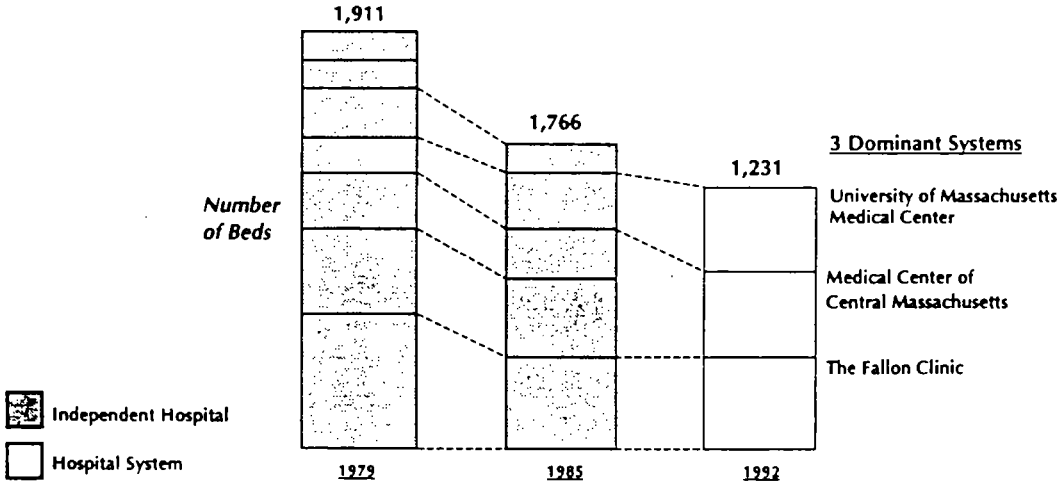
[9] see section 2.5.2

[10]Lutz, Sandy, "NME, AMI to Merge," *Modern Healthcare,* 10/17/94.

FIGURE 9

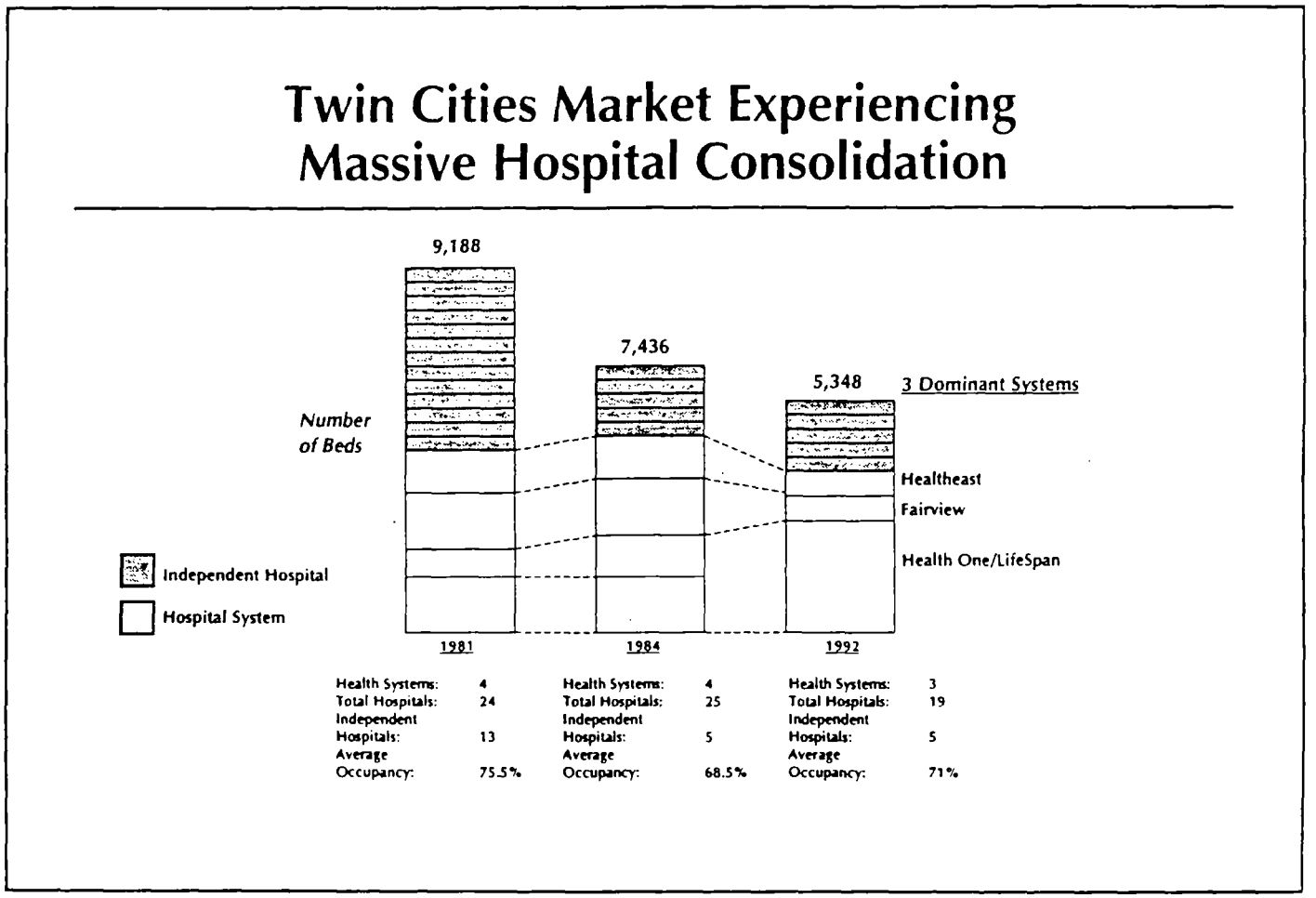
Hospital Market in Worcester, Mass., Concentrated with Three Dominant Systems



1979		1985		1992	
Health Systems:	0	Health Systems:	0	Health Systems:	3
Total Hospitals:	7	Total Hospitals:	5	Total Hospitals:	4
Independent Hospitals:	7	Independent Hospitals:	5	Independent Hospitals:	0
Average Occupancy:	75.4%	Average Occupancy:	72.9%	Average Occupancy:	79.8%

Source: *AHA Guide to the Healthcare Field*, 1979-1992, American Hospital Association, Chicago, Illinois.

FIGURE 10



Source: *AHA Guide to the Healthcare Field*, 1979-1992, American Hospital Association, Chicago, Illinois.

1.3.3 Issues Raised by Opponents of Competitive Managed Care Systems

Economic Efficiency

Some analysts believe that competitive health systems are not an economically efficient means of providing health care services. They argue that there are many elements of market failure in the American health care system and that regulatory measures are needed to make markets work. Some analysts argue that because of market failure on the demand side, supply side regulations are needed to control cost. A brief discussion of health market failure is presented in Section 2.2. Individuals who believe that competitive health markets do not work, logically precede any discussion of the relative merits of pro-competitive systems with those issues.

Managed Care

The efficacy of managed care is an issue raised by some health analysts. Proponents of managed care cite the literature on its success in California (presented in Section 2.3). Opponents of managed care pose questions such as: will managed care work over the long term? Will it be effective in covering all populations or has it benefited from selection of healthier populations? Does managed care increase productivity or does it simply shift cost from one area to another? If there are real efficiencies from managed care, will the savings be passed on to consumers?

Community Models of Care

Some health researchers and health policy theorists believe that a community, and not the market, can best allocate health resources to its members. They believe that the most equitable and efficient allocation of health resources and services can best be effected by health planning at the community level. Some hospitals also share this belief. The AHA supports community models within a pro-competitive system in which hospitals both compete and collaborate. Some hospitals support a community model that is regulatory in nature, in which planning is effected at the community or state level. Hospitals have a long tradition of service to their community and feel threatened by the economics of strong antitrust enforcement.

Access to Medical Care

Opponents of competitive systems argue that without regulation, access to care may become problematic. They argue that competition will resolve excess capacity by closing hospital facilities without regard to the needs of the communities in which they reside. They argue that hospitals that serve poorer communities and that provide disproportionate amounts of charitable care will be most at risk in a competitive environment. Those concerned with access argue that competitive systems have the incentive to avoid contracting with physicians, hospitals and employers that serve communities with higher than expected medical costs.

Incentives to Provide Quality of Care

The advent of competition and managed care have changed the payment incentives in the health industry. In the past, providers were reimbursed by payers on a fee-for-service basis, and thus had positive incentives to provide more services. The incentives under managed care, especially in a capitated system, shift the risk from payer to provider. Opponents of managed care argue that the provider now has the incentive, at least in the short term, to provide less service.

Advocates of capitated systems argue that fee-for-service was a chief failing of our system and that it gave providers the perverse incentive to provide unnecessary services. Furthermore, they argue that since capitated systems are financially at risk for all of a patients future health expenses, they have the incentive to provide the best preventive care and most cost effective care over the life of the patient.

Incentives also differ between for-profit and non-profit institutions. Opponents of competitive systems argue that under the profit motive, hospitals and other providers will have the incentive to reduce quality in order to maintain profit margins and the return to stock and bond holders..

2.0 COMPETITIVE AND CONCENTRATED MARKETS: A SUMMARY OF THE RECENT LITERATURE

2.1 OVERVIEW

Considerable research has been performed on the relative economic effects of competitive and concentrated health care markets. There are three primary questions pertinent to this topic: What is the most efficient system in terms of cost, access and quality? Are different systems appropriate for different size or types of health markets? Are antitrust enforcement policies consistent with the range of appropriate models?

Those that favor competitive models reference a growing body of literature that shows that selective contracting in a competitive environment has worked well in California. Supporters of competitive models point to the success of competition in reducing costs in large markets and warn that easing antitrust in smaller markets will foreclose the potential for managed care and selective contracting. They point to the recent moderation in price increases nationwide as evidence that competition is making health markets more efficient. Supporters of competitive models cite the value of past antitrust enforcement in the health sector, and advocate strict antitrust enforcement to preserve competition.

Those that favor regulated or community models argue that hospitals tend to be quality maximizers and do not primarily compete on price. Many believe that the extent of market failure and of government participation in the health sector make some degree of regulation inevitable. Proponents of regulation are more apt to separate large and small markets and believe, at least in markets that do not appear large enough to sustain competition, that communities can best consolidate excess capacity and most efficiently allocate health services by planning and regulating the delivery of services. Supporters of regulated markets recommend more flexible antitrust laws and often advocate antitrust exemptions and safe harbors for the implementation of these models. They reference well respected research studies that conclude that costs have not been higher in concentrated markets. However, these studies pre-date the emergence of selective contracting and leave unanswered the question of the relative importance of non-price competition in competitive markets.

2.2 ARE HEALTH MARKETS DIFFERENT?

Some economists believe that there are peculiar characteristics of health markets that cause some degree of market failure. They believe that competition in these markets will not work efficiently without some degree of regulation. It is beyond the scope of this paper to explore the theoretical basis of these arguments. Since this viewpoint informs peoples decisions, however, the major elements concerning market failure are listed on the following page without explanation:

- An asymmetry of information between providers and consumers makes informed decision making by consumers difficult.
- The widespread existence of insurance causes moral hazard
- An asymmetry of information allows adverse selection of insurance by consumers
- An asymmetry of information and "agency" relationship allows providers to induce demand
- Insurers attempt to avoid risk by seeking to insure healthy people.
- Consumers have a propensity to demand unlimited care when confronting death
- There is a substantial presence of government purchasers (Medicare, Medicaid, etc.), some of whom have instituted regulated prices.
- Hospitals have a propensity to be quality maximizers rather than profit maximizers.
- There is a substantial presence of non-profit institutions which have different incentives than for-profit businesses.

2.3 COMPETITIVE MODELS AND THE COST OF HOSPITAL CARE

Researchers who have studied costs under competitive models of health care have primarily examined the market in California. In 1982 California became the first state to pass legislation authorizing selective contracting and it was there that managed care achieved its first widespread penetration. The legislation allowed contracts that promised providers patient referrals (through co-payment incentives) in exchange for reductions in fees.

Zwanziger and Melnick[11] (Z&M) examined the California market from 1980 to 1985. They recognized that previous to their study, "All of the empirical studies on the effects of hospital competition have concluded that greater hospital competition leads to higher hospital costs." Z&M cited many of these studies and accepted the thesis that before 1982, hospital competition was characterized by quality and amenities and not by price. Z&M cautioned, "These studies, based on data from 1982 or before, however, are silent with regard to the implications of selective contracting." Their study compared costs before and after the enactment of selective contracting legislation in areas with competitive markets. Their results indicated a strong price effect from competition and found that the previously existing difference in price between small and large markets substantially declined with the advent of selective contracting.

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[11]Zwanziger, Jack and Melnick, Glenn A., "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," *Journal of Health Economics*, 457, 1989.

Robinson and Luft[12] confirmed Z&M's findings. They examined data on 5,490 hospitals and compared the costs of all-payer regulated models in MA, MD, NY and NJ, and the competitive model in California with costs in all other areas of the United States. They found that CA reduced its inflation rate by 10.1% compared with control hospitals in 43 states[13]. Significantly, they found that those hospitals that had more than 10 neighbors (within a 15 mile radius), reduced inflation by 21.7% relative to the control states. Hospitals that had less than 10 neighbors, however, exhibited no reduction relative to the control states.

Robinson examined the California market again between 1982 and 1988.[14] He supported the thesis that previous studies concerning HMO market penetration and costs were not valid because laws did not permit selective contracting. Those studies, he claimed, reflected competition by quality and not cost. Robinson examined 298 non-HMO hospitals and found that the average growth rate for costs per admission were 9.4% lower in markets with high HMO penetration.[15] He also confirmed a large difference in areas that had the most competition. Those with 24 or more neighbors within a 15 mile radius had a 15.5% lower rate of inflation relative to hospitals in markets with a low HMO penetration, while those with less than 24 neighbors had a 4.2% lower inflation rate.

Dranove et. al. also examined the California market from 1983 through 1988.[16] They identified different health markets as being patient driven or payor driven. They theorized that patient driven markets conformed to the quality maximizing paradigm in which increasing competition did not lead to lower prices. On the other hand, they found that payor driven markets that existed in California under selective contracting conformed to the traditional competitive paradigm. Dranove et. al. found that net markup decreased from .165 to .045 in markets that were highly competitive.

Dranove et. al. also constructed a model to predict the effect of further market concentration. Their model predicted that a decrease in the number of hospitals in a market from five to

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[12]Robinson, James C., and Luft, Harold S., Competition, Regulation and Hospital Costs, 1982-1986," 260, *Journal of the American Medical Association*, 3241, 1987.

[13]They also found that all-payer systems reduced costs by 16.3% in MA, 15.3% in MD and 6.3% in NY compared to the control states.

[14]Robinson, James C., "HMO Market Penetration and Hospital Cost Inflation in California," 266, *Journal of the American Medical Association*, 2719, 1991.

[15]It should be noted that this is in the context of a 74.5% price increase over the period studied.

[16]Dranove, David, et. al., "Price and Concentration in Hospital Markets: The Switch from Patient Driven to Payor Driven Competition," unpublished, 3/17/92.

four, would cause an increase in markup of .028 (a number which was more than half of the existing markup in his model of .045). Dranove concluded that increases in concentration, even in competitive markets, can cause significant increases in price.

Melnick and Zwanziger, in a 1992 study[17], examined relative prices that were negotiated by Blue Cross of California in 1987 with various hospitals in their PPO network. They found that Blue Cross paid significantly higher prices to hospitals located in less competitive markets. They also found that the more dependent the hospital was on Blue Cross, the greater discounts Blue Cross was able to obtain. Conversely, they found that the more dependent Blue Cross was on a particular hospital, the less of a discount Blue Cross could negotiate. In addition, M&Z found that excess capacity was an extremely important variable, indicating that hospitals with high occupancy could negotiate much higher rates.

M&Z also estimated the effect of a merger on negotiated prices. They assumed a reduction in competing hospitals in a market from three to two, and predicted a resulting price increase of 9%. They considered that to be a probable underestimate because of limitations in their model. M&Z concluded that the competitive pressures that they predicted in their previous California studies had now materialized. They cautioned that small increases in concentration, which give firms more market power and a higher portion of each payor's potential business, can cause significant increases in price.

It is instructive to note that Melnick, Zwanziger and Dranove have all expressed concern about concentration in larger or more competitive markets. This has implications for antitrust policy that were summarized by Zwanziger in a 1989 study[18]:

> "...it is antitrust enforcement that appears to be paradoxical. Hospital mergers in relatively small urban centers are being prevented, often in markets with limited PPO or HMO presence, where hospitals tend to compete on quality, and so cost increasing basis. At the same time, mergers in larger urban areas are allowed to proceed where they could erode the ability of PPOs and HMOs to promote price based, cost lowering competition between hospitals."

Richard Kronick et al[19]point out a limitation in the potential savings that can be derived through competition. Estimating the population that would be sufficient to support 3 independent health plans, they conclude that only 42% of U.S. health markets are large

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[17]Melnick, Glenn A., Zwanziger Jack, et. al., " The Effects of Market Structure and Bargaining Position on Hospital Prices," *Journal of Health Economics*, 1992.

[18]Zwanziger, Jack, "Antitrust Considerations and Hospital Markets," *Journal of Health Economics*, 457, 1989.

[19]Kronick, Richard, Goodman, David C., et. al., "The Demographic Limitations of Managed Competition," *The New England Journal of Medicine*, 1/14/93.

enough to support a full model of managed competition. They conclude:

> "Reform of the U.S. health care market through managed competition is feasible in medium sized or large metropolitan areas. Smaller metropolitan areas and rural areas would require alternative forms of organization and regulation of health care providers to improve quality and economy."

2.4 CONCENTRATED MARKETS AND THE COST OF HOSPITAL CARE

There have been a number of research studies that measure the cost of hospital care relative to the concentration of hospital markets. Excluding the studies done in California after the institution of selective contracting, most of these studies conclude that costs in more concentrated markets are equal to or less than costs in markets where competition is more prevalent. This is consistent with the theory that hospitals compete on quality and amenities rather than price. Hence, we have two sets of literature on this subject. The so called "old literature" is abundant and well documented, and is consistent with the theory of quality maximization, but it precedes studies of markets in which selective contracting has taken hold. The "new literature," based primarily on the selective contracting experience of California, is not as plentiful and has not been tested over a long period of time. However, it does indicate the cost saving potential of selective contracting, particularly in markets with many competitors.

Robinson and Luft, in a well known study[20], examined data from 5,732 U.S. hospitals from 1982. They found that costs per admission were 26% higher in areas that had more than 10 hospitals within a 15-mile radius versus areas in which there were no competitors. Similarly, they found that costs per patient day were 15% higher. They compared their results with earlier studies that they undertook with data from 1972 and found the results to be consistent. These findings support the quality maximizer and "medical arms race" theories. The authors predict that competitive models, under selective contracting, may reduce cost, but even in those instances non-price competition will continue to play an important role.

Robinson and Luft published a later study in 1988[21] that was referenced in the preceding section. It compared cost inflation rates in the all-payer rate regulated states of MA, MD, NY, and NJ from 1982 to 1986 with control hospitals in 43 states (excluding CA). They found that regulation reduced the rate of cost inflation by 16.3% in MA, 15.4% in MD and 6.3%in NY. The rate in NJ was approximately equal to the control group, but the authors pointed out that NJ began with the lowest costs having had a strong regulatory control program in the 1970's. They found that areas with more than 10 hospitals within a 15 mile

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[20]Robinson, James C. and Luft, Harold S., "Competition and the Cost of Hospital Care, 1972-1982," 257, *Journal of the American Medical Association*, 3241, 1987.

[21] Robinson and Luft supra #12.

radius tended to have higher rates of inflation than those areas with less than 10 hospitals.

In 1990 a study by Health Care Investment Analysts[22]examined hospital charges in over 2000 U.S. hospitals having 100-400 beds. Median charge per patient was measured for 3 categories of market concentration. The charges in the most competitive regions were 14% higher than those in moderately competitive markets and 24% higher than those in single hospital communities.

A number of older studies also support the"quality maximizer" theory. Joskow[23] in 1980 found that hospitals in more competitive markets kept a larger reserve supply of beds. Wilson and Jadlow[24] in 1982 found that markets with greater competition had lower technical proficiency in their delivery of services. Farley[25] in 1985 found that in markets that were more competitive, the cost of labor and capital per patient was higher and that there were a greater number of procedures performed for patients with similar diagnoses.

Dranove et al, in an article published in 1992[26], disagreed with the "medical arms race (MAR)" theorists. They argued that studies that measure the number of providers in a market, but which did not consider market size, overestimated the effect of competition on prices. Dranove et. al. stated that the study "cannot completely rule out the MAR hypothesis," but that the findings suggest that the importance of the MAR was generally overstated. The authors did state, however, that "our results suggest that there may be unexploited scale economies in smaller markets."

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[22] "Health Care Investment Analysts, United States Hospitals Charges 1984-1988"(1990). This study is referenced in Richard Koenig," Lots of Hospitals Can't Add Up to Lower Prices," *Wall Street Journal*, 4/5/90 at B1.

[23]Joskow, Paul L., "The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital," *The Bell Journal of Economics*, 11 Autumn 1980 from Zwanziger and Melnick, supra #1.

[24]Wilson, George W. and Jadlow, Joseph M., "Competition Profit Incentives and Technical Efficiency in the Provision of Nuclear Medicine Services, *The Bell Journal of Economics*, 13 Autumn 1982, from Zwanziger and Melnick, supra #1.

[25]Farley, Dean E., "Competition Among Hospitals: Market Structure and Its Relation to Utilization, Costs and Financial Position," Research Note 7, Hospital Studies Program, National Center for Health Services Research and Health Care Technology Assessment, from Zwanziger and Melnick, supra #11.

[26]Dranove, David, et. al., "Is Hospital Competition Wasteful? "*Rand Journal of Economics,* 247, 1992.

Several researchers examined markets in which mergers have occurred in an effort to measure the effects of the mergers on costs and prices. The Office of the Inspector General of Health and Human Services (HHS) reported on hospital mergers in 1992[27]. The study examined markets in which mergers occurred compared to control markets in which there had been no mergers. The findings showed that medical and service costs were 10.4% lower in post-merger markets versus an increase of 29.7% in the control markets.

Greene examined 14 hospital mergers that occurred between 1985 and 1990.[28] He found that average charges and net revenues rose very slightly, but at a lower rate than the average increase nationally. Cost per case also rose at a lesser rate in the merged hospitals.

Eisenstadt[29]examined prices in 8 markets in which there were mergers between non-profit hospitals and compared them to control markets. He found that the markets that had mergers did not experience statistically significant increases in price. However, his study has been criticized for the use of list prices that did not reflect discounts.

The preceding studies raise questions of whether traditional economic theory of higher prices in less competitive markets can be applied to hospital markets. However, these studies do not distinguish between markets with and without selective contracting. Hence, in the current debate, they may provide insight into how competition was, but may not inform us as to how important non-price competition may be under selective contracting.

2.5 OTHER ECONOMIC ISSUES

2.5.1 Specialization

Researchers have found that hospitals that perform complex procedures more frequently have better patient outcomes than those that perform the same procedures infrequently. Luft et al[30]studied 12 surgical procedures in 1498 hospitals. In 4 of these procedures[31] they found

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[27]Office of the Inspector General, U.S. Department of Health and Human Services, Effect of Hospital Mergers on Costs, Resources and Patient Volume," 1992.

[28]Greene, Jay, "The Costs of Hospital Mergers," *Modern Healthcare,*p. 36, 2/3/92.

[29]Eisenstadt, David M. and Masson Robert T., "Price Effects from Recent Non-Profit Hospital Mergers", presentation at American Public Health Association Meeting, Chicago, IL, 10/23/89.

[30]Luft, Harold, et. al., "Should Operations Be Regionalized? The Empirical Relation Between Surgical Volume and Mortality," *New England Journal of Medicine*, p. 1364-1369, 12/20/79.

that death rates were 25-41% lower for hospitals that performed over 200 operations compared to hospitals with lower volume. Some proponents of regulation believe that complex procedures such as these should be allocated to specific specialty centers in order to improve health outcomes. However, such an allocation of services is a per se violation of the antitrust laws.

2.5.2 Economies of Scale

There has been a good deal of research concerning the most efficient size of hospitals. It has been argued that small hospitals cannot operate efficiently due to economies of scale and that they should be allowed to merge to create more efficient organizations. Cowing et al[32], in a review of the literature in this area concluded that there are economies of scale in hospitals up to approximately 200 beds. James Egan, the Director of Litigation for the FTC Bureau of Competition, testified in the Senate on 5/7/93:

> Most hospital scale economies are exhausted at 100 beds. Above 100 beds, up to somewhere over 200 beds, increases in hospital size and volume may be associated with some scale economies, but those economies are usually not substantial."

The government has now specified a safe harbor for the merger of small hospitals. Mergers that involve one hospital with fewer than 100 beds, less than 40 patients per day, and which are less than 5 years of age will not be challenged.

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[31]The four procedures were open-heart surgery, vascular surgery, transurethral resection of the prostate, and coronary bypass.

[32]Cowing, Holtman, and Powers, "Hospital Cost Analysis: A survey and Evaluation of Recent Studies," *Advances in Health Economics and Health Services Research*, 257, 1983.

3.0 ANTITRUST LAW AND ITS APPLICATION TO THE HEALTH CARE INDUSTRY

3.1 OVERVIEW

Until 1975[33] antitrust was of little concern to the health care industry. Hospitals were considered professional and/or charitable institutions that were not subject to economic regulation.[34] Beginning in the mid 70's and continuing to the present time, the government has satisfied the courts that it has jurisdiction over both for-profit and non-profit organizations within the health industry. Significantly, competition emerged in the health care sector partly as a result of an FTC action against the American Medical Association (AMA) in 1979. In that case, the FTC was able to outlaw an AMA regulation prohibiting physicians from working on a salaried basis for hospitals or HMOs.[35]

In the early 1980's the government brought several antitrust actions to prevent hospital mergers. Fearing the specter of strong government enforcement, industry representatives, particularly the American Hospital Association (AHA), expressed concern that antitrust enforcement was impeding industry attempts to become more efficient through consolidation. They claimed that government policy was having a "chilling effect," discouraging organizations from undertaking collaborative activities because of the potential expense and uncertainty inherent in the legal process.

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) attempted to respond to industry concerns and have sought to reduce uncertainty and provide greater clarity in regard to the enforcement process. In that regard the agencies jointly issued "Horizontal Merger Guidelines" in 1992 outlining the analytic process employed in the evaluation of mergers and acquisitions. Subsequently, "Joint Policy Enforcement Statements" were issued in 1993 and 1994, which updated the 1992 Guidelines and set forth safe harbors for certain specific activities.

During this period the legislative branches of both federal and state government also became involved in these issues. A number of bills were filed in the 103rd Congress to create safe harbors, exempt certain activities and encourage collaboration among medical providers. While the Congress did not act on any of these initiatives, some of the legislative proposals may resurface in the next congressional session. Meanwhile 24 states, acting under the Doctrine of State Action Immunity (see Section 3.5), have provided potential exemptions from federal antitrust to providers acting in conjunction with state regulatory plans.

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[33]Goldfarb vs. Virginia State Bar, 421 U.S. 773 (1975)

[34]The Governance One Hundred, Hospitals and Antitrust in the 1990's: Understanding the Risks in a Changing Environment (Spring 1994)

[35]AMA, 94 F.T.C. 701 (1979); 638f.2d 443 (2nd Cir. 1980); 455 U.S. 676 (1982)

The statutory laws that have been the basis for antitrust enforcement apply to American industry in general and are not specific to the health sector. There are 3 statutes briefly summarized below, of which Section 7 of the Clayton Act is employed most often for hospital mergers and acquisitions.

The FTC and the DOJ receive notification of mergers, acquisitions, joint ventures, and tender offers pursuant to the Hart-Scott-Rodino Antitrust Improvement Act of 1976.[36] The act is not specific to the health industry. It requires that parties give advance notification to both the FTC and the DOJ for the above mentioned activities provided that the net sales or net assets of the acquiring hospital is at least $100 million and the hospital being acquired has assets of at least $10 million.

3.2 STATUTORY LAW

Antitrust concerns in the health care industry can be divided into the following three classifications[37]:

- Mergers and acquisitions of hospitals, provider groups and insurers.
- Horizontal restraint cases such as joint ventures, allocation of services, cooperative arrangements, and trade association rules.
- Input market monopolization such as hospital privileges and managed care credentialing.

The basis for bringing antitrust challenges against these actions are provided by the following statutes:

Section 7 of the Clayton Act

Section 7 of the Clayton Act prohibits mergers, acquisitions, and joint ventures that may substantially lessen competition or tend to create a monopoly. The enforcement of this statute is not dependent on intent, and it sets a standard that measures the future consequence of present actions ("may substantially lessen ... or tend to") rather than the present market condition. For these reasons, the burden of proof required of the government is most easily attained under this statute and it is the one that is most frequently employed in merger and acquisition cases.

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[36]P.L. 94-435, 15 U.S.C. 18A

[37]Vita Michael G., et. al., "Economic Analysis in Health Care Antitrust," *Journal of Contemporary Health Law and Policy,* 73, 1991.

Section 1 of the Sherman Act

Section 1 of the Sherman Act prohibits contracts, conspiracies, and combinations in restraint of trade. This section may be applied to mergers, acquisitions and joint ventures, but the burden of proof in these areas is greater than that in Clayton 7. It is usually applied to a variety of other activities including allocation of services, trade association rules, exclusive contracts, tie-ins, boycotts, fee schedules, and other kinds of joint conduct. Because of the breadth of it jurisdiction it is probably the most frequently employed statute in health cases.

Section 2 of the Sherman Act

Section 2 of the Sherman Act prohibits conduct that monopolizes, intends to monopolize or conspires to monopolize. It is not employed as frequently in health sector cases as the two statutes mentioned above.

3.3 HORIZONTAL MERGER GUIDELINES

The intent of the antitrust statutes is assure that no organization can accumulate enough market power to adversely affect consumer welfare. In the case of mergers and acquisitions, Kevin J. Arquit, the former director of the FTC stated[38] :

> "... the ultimate inquiry in merger analysis is whether the merger is likely to create or enhance market power or to facilitate its exercise."

Market power for a seller is the ability to maintain prices (adjusted for quality) above competitive levels for a significant period of time. Market power for a buyer is the ability to depress prices (adjusted for quality) below competitive levels and, therefore, depress output.

There are two standards of analysis in the enforcement of these laws. Some joint agreements are "per se" illegal under the antitrust statutes. Sometimes called "naked restraints," these agreements are so unlikely to produce benefits to consumers that they are deemed illegal without the benefit of any analysis. Examples of "per se" violations are price fixing agreements, agreements to allocate markets, and group boycotts. Agreements that are not "per se' violations are subjected to a "rule of reason analysis."

The subjects of this study, mergers, acquisitions, and legitimate joint ventures (as opposed to "sham" joint ventures") are all subject to a rule of reason analysis. Agreements to allocate services, such as concentrating cardiac care in one hospital and neo-natal intensive care in

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[38]Arquit, Kevin J., "1992 Horizonal Merger Guidelines," FTC Director's Views, a speech before the American Bar Association, Section of Antitrust Law, reprinted by Commerce Clearing House, Inc., p. 48,814, 1992.

another, are per se violations, unless they are part of a legitimate joint venture agreement.[39]

The rationale behind the rule of reason analysis is to first ascertain whether an activity will enable a firm to exercise market power in an anti-competitive fashion; and then to analyze whether there are efficiencies gained that outweigh the anti-competitive effects. The methodology consists of a five step process as follows:

1. Define the geographical and product market and measure the degree of concentration within that market.

2. Assess the potential anti-competitive effects.

3. Assess whether new entries into the market will counteract anti-competitive effects.

4. Analyze efficiencies to determine whether efficiencies gained outweigh the anti-competitive consequences.

5. Consider any "failing firm" defense to ascertain if the market is likely to consolidate through the financial failure of one of the merged parties absent the merger agreement.

The government has emphasized that this process needs to be flexible in order to respond to the characteristics of individual cases and that the guidelines are meant to provide an analytical framework for assessing the potential competitive effects of mergers and acquisitions. A detailed description of the rule of reason methodology, in accordance with the horizontal merger guidelines, is presented in Section "A" of the Appendix.

3.4 ANTITRUST ENFORCEMENT POLICY STATEMENTS

The FTC and the DOJ issued joint policy statements in September 1993 to help resolve uncertainty as to their enforcement policies. On September 27, 1994 the agencies issued nine new and/or revised statements which updated and expanded on their previous efforts. These statements specify antitrust safety zones, explain the methodology employed when actions fall outside of these safety zones, and commit both agencies to expedited reviews in response to inquiries about the legality of proposed collaborative actions. The areas covered by these statements are listed below. A detailed summary of the review policies is presented in Appendix "B."

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[39]A "legitimate" joint venture involves some amount of integration between the parties and a sharing of financial risk. This is discussed further in Appendix B, statement #8.

Enforcement Policy Statements

1. Mergers among hospitals
2. Hospital joint ventures involving high technology or other expensive health care equipment
3. Hospital joint ventures involving specialized clinical or other expensive health care services
4. Providers' collective provision of non-fee-related information to purchasers of health care services
5. Provider's collective provision of fee-related information to purchasers of health care services
6. Provider participation in exchanges of price and cost information
7. Joint purchasing agreements among health care providers
8. Physician network joint ventures
9. Analytical principles relating to multiprovider networks

Review Procedures

The agencies will respond to request for business reviews or advisory opinions regarding any matters expressed in these statements within 90 days of receiving all necessary information, except requests regarding multiprovider networks and hospital mergers outside the safety zone. The agencies will reply within 120 days of receiving all necessary information regarding multiprovider networks and non-merger health care matters not addressed in the guidelines. Statutory deadlines already exist for the antitrust review of most mergers.

3.5 DOCTRINE OF STATE ACTION IMMUNITY

The doctrine of state action immunity provides a procedure for states to exempt private organizations within the state from federal antitrust statutes. State action immunity is not specific to the health industry and is not a legislative initiative. It is a doctrine that "rests on principles of federalism and state sovereignty,"[40] and is articulated in Parker v. Brown 317 U.S. 341 (1943) and other cases including, more recently, FTC v. Ticor Title Ins. Co., 112 S. Ct. 2169, 2176 (1992). There is a two part test to meet the standards of state action immunity:

1. The state must "clearly articulate and affirmatively express a policy to displace competition with regulation."

[40]324 Liquor Corp. v. Duffy, 479 U.S. 335, 343,1987, from Kopit, William G., "State Antitrust Initiatives," Atlantic Information Services, Inc., 1994.

2. The state must have the power to regulate the particular area and must "exercise its power to actively supervise the activity."[41]

Between March, 1992 and June, 1994 18 states instituted programs to exempt hospitals and other health care providers under state action immunity.[42] Figure 12 summarizes the action of these states. Since that report six other states have instituted similar actions.

It is not known how much supervision is required by the states to shield private organizations from federal antitrust. In FTC v. Ticor Title Insurance Co. the court ruled that a program that deemed that prices were approved by the state if not expressly disallowed did not constitute sufficient supervision. In our recent discussions with the FTC and the DOJ, they indicated that the supervisory standards could be quite rigorous and that there existed a reasonable possibility that the agencies would challenge some state immunity plans. At this time, the importance of these plans cannot be determined, but it does appear that private organizations would have to submit to substantial regulation in order to be assured of federal immunity.

3.6 FEDERAL LEGISLATIVE INITIATIVES

During the health reform debate in the 103rd Congress, hearings were held and legislation was introduced to address concerns regarding the enforcement of antitrust laws in the health industry. These legislative initiatives were generally supported by hospitals, physicians, and other providers and were opposed by insurance companies and managed care plans. They commonly contained the following kinds of provisions: safe harbors for collaborative activities; market screens to provide exemptions for small mergers; antitrust exemptions under specified conditions; increased legal protection for collaborating parties; and a certificate of review process for certain collaborative activities.

Congress did not act on any of these initiatives, but there is one bill that might still be relevant in the 104th Congress. This bill is entitled the "Hatch-Thurmond Health Care Antitrust Improvements Legislation" which was attached to the Dole-Packwood health care reform bill (S. 2374). This bill was a revision of the previous "Health Care Antitrust Improvements Act introduced by Senators Hatch and Thurmond in the Senate (S.1658) and Representative Archer in the House (H.R. 3486). The stated purpose of the bill is to improve the quality of health care and to reduce cost to the consumer. The bill sets forth

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[41]Kopit, William G., "State Antitrust Initiatives," Atlantic Information Services, Inc., 1994.

[42]U.S. General Accounting Office, "Federal and State Antitrust Actions Concerning the Health Care Industry," GAO/HEHS-94-220, 8/94.

FIGURE 11

Table 2: Key Features of State Regulatory Programs Concerning Antitrust Enforcement

State	Activities covered	Providers covered	Approval agency	Limitations
Colorado	Joint ventures and agreements for the allocation, consolidation, or referral of patients, services, and facilities	Hospitals	Cooperative Health Care Agreements Board	Program to sunset in July 1998
Florida	Joint ventures	Certified rural hospitals and other certified rural health care providers	Agency for Health Care Administration	Antitrust exemptions apply only to rural health care networks[a]
Georgia	Mergers	Specified hospitals	Governing authority of the county and a majority of each hospital board	Applies only to county hospital authorities in the same county
Idaho	Joint ventures	Hospitals, physicians, and other health care providers	Attorney General	
Kansas	Mergers and joint ventures	Hospitals, physicians, and other health care providers	Secretary of the Department of Health and Environment	
Maine	Joint ventures	Hospitals	Department of Human Services	Program to sunset in July 1995
Minnesota	Mergers and joint ventures	Hospitals, physicians, and other health care providers	Commissioner of Health	
Montana	Joint ventures	Hospitals, physicians, and other health care providers	Health Care Authority	
Nebraska	Joint ventures, and allocation, consolidation, or referral of patients, services, and facilities[b]	Hospitals, physicians, and other health care providers	Department of Health	
New York	Joint ventures	Hospitals, physicians, and other health care providers	Commissioner of the Department of Public Health	Applies only to rural health care networks[a]
North Carolina	Joint ventures	Hospitals	Director of the Department of Human Resources	
North Dakota	Joint ventures	Hospitals, physicians, and other health care providers	Department of Health and Consolidated Laboratories	
Ohio	Joint ventures	Hospitals	Department of Health	
Oregon	Joint ventures	Hospitals	Department of Human Resources	Applies only to heart and kidney transplant services, and must include services at the state teaching hospital
Tennessee	Joint ventures[c]	Hospitals	Department of Health	
Texas	Joint ventures	Hospitals	Department of Health	
Washington	Joint ventures[d]	Hospitals, physicians, and other health care providers	Health Services Commission[e]	Different rules apply to rural public hospital districts[f]
Wisconsin	Joint ventures	Hospitals, physicians, and other health care providers	Department of Health and Social Services	

four means of accomplishing these goals:[43]

1. The bill instructs the FTC and the DOJ to establish safe harbors in certain specified categories. Rather than specifying any details or limits within those categories, it instructs the agencies to propose those details. Creating safe harbors in this fashion provides legal protection to the collaborating parties as opposed to the joint enforcement policy statements which have no legal effect on the courts. Hence, even if the safe harbors are the same as those proposed in the policy statements (and they are quite similar), they provide legal protection against state, federal and private lawsuits. Notwithstanding the above, they specify that activity within a safe harbor is subject to antitrust action for "injunctive relief." The bill specifies 10 categories:

    a. Joint purchasing of health care services
    b. Small hospital mergers
    c. Network formation and operation
    d. Medical self-regulatory entities
    e. Provision of information by providers
    f. Participation in surveys
    g. High-tech and tertiary joint ventures
    h. Market power screens
    i. Joint purchasing arrangements
    j. Good faith negotiations

2. The bill provides a process by which collaborating parties can seek certificates of review from the FTC and the DOJ. These certificates will provide more legal protection than the former advisory opinions. However, private, state and federal antitrust action for injunctive relief to stop anticompetitive conduct covered by a certificate of review will be permitted. The bill specifies that the government must take into account concerns such as access to care in under-served areas in analyzing requests for certificates.

3. The bill creates a notification process for providers who intend to form joint ventures. If the participants in the joint venture are later sued, they are guaranteed a rule of reason analysis and are subject only to actual damages (as opposed to treble damages under existing law).

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[43]Material from the following section utilized an unpublished document from Seat, Keith L., "Summary of Hatch-Thurmond Health Care Antitrust Improvements Legislation,"8/94.

4. The bill directs the agencies to issue further guidelines pertaining to the following categories:

   a. Product and geographic market definitions
   b. Special rules for under-served areas, such as rural or inner city markets
   c. Provider networks
   d. Community health centers
   e. The subject matter of the safe harbors specified in #1, above.

Both the FTC and the DOJ have publicly opposed the measures listed in this bill. However, the enforcement policy statements issued by the agencies in September, 1994 (summarized in the appendix) closely resemble some of these provisions. It is likely that providers will continue to lobby for these kinds of measures in the next Congress, and that they will be opposed by insurance companies and managed care organizations.

3.7 ANTITRUST LIMITATIONS IN OTHER INDUSTRIES

There are at least two precedents for statutory limitations of antitrust laws that apply to particular industries. These are, the Newspaper Preservation Act[44] and The National Cooperative Research Act of 1984.[45]

Newspaper Preservation Act

Congress succinctly defined the rationale for allowing antitrust exemptions in the newspaper industry as follows:

> "In the public interest of maintaining a newspaper press editorially and reportorially independent and competitive in all parts of the United States, it is hereby declared to be the public policy of the United States to preserve the publication of newspapers in any city, community, or metropolitan area where a joint operating agreement has been heretofore entered into because of economic distress or is hereafter effected in accordance with the provisions of this chapter."[46]

The act provided that newspaper companies could obtain written consent for future joint agreements. It explicitly warned that predatory practices would not be exempt.

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[44]Newspaper Preservation Act, 15 U.S.C. 1801 et seq

[45]The National Cooperative Research Act of 1984, 15 U.S.C. 4301 et seq

[46]Newspaper Preservation Act supra # 44

The National Cooperative Research Act of 1984

Congress established a limitation on antitrust damages that can be assessed against firms that undertake cooperative research to accomplish technological innovations. The rationale for this legislation was as follows:

> "Technological innovation and its profitable commercialization are critical components of the ability of the United States to raise the living standard of Americans and to compete in world markets. Cooperative arrangements among non-affiliated businesses in the private sector are often essential for successful technological innovation. The antitrust laws may have been mistakenly perceived to inhibit procompetitive cooperative innovation arrangements ...it is the purpose of this act to promote innovation ...by clarifying the applicability of the rule of reason standard and establishing a procedure under which businesses may notify the DOJ and the FTC of their cooperative ventures and thereby qualify for a single-damages limitation on civil antitrust liability."[47]

[47]The National Cooperative Research Act of 1984, supra # 45

4.0 CONCLUSION

We have attempted to provide an explanation of the economic forces causing consolidation in the health care industry. The emergence of competition and the growth of managed care is changing the nature of American health markets. HMOs have enrolled nearly 50 million Americans and, as they continue to grow, they have acquired more control over the financing and delivery of care. Hospitals and physicians, seeking to compete in this new economic environment, have engaged in mergers, acquisitions and joint ventures in order to become more efficient and to increase their bargaining power with managed care plans.

This activity is transforming the structure of the health care industry even without the enactment of national health reform legislation. During the 103rd Congress, comprehensive health reforms were proposed and even minute policy details were subject to extensive public debate. But the current struggle for control of our health delivery system is being determined in the board rooms of private corporations and medical institutions without the benefit of public scrutiny.

The arbiters of this struggle are the antitrust departments of the FTC and the DOJ. With no other public guidance, their enforcement policies could determine the extent of market consolidation and the balance of power among competing forces. This raises several questions worthy of consideration:

- Are these regulatory agencies qualified to decide complex issues of health policy involving not only economic efficiency but also quality of health care and equitable access to medical services?

- Should public policy issues of this magnitude, that affect the health care of all Americans, be left to a regulatory agency, without the benefit of open, public debate and the guidance of informed public policy?

The issues that are the basis for such a debate involve difficult economic principles and have no certain resolution. The ultimate question is, what kind system will provide the best health care in terms of cost, access and quality? Is that system one of competitive managed care networks? If so, what is the correct balance between integration and consolidation, and what questions are raised by each alternative?

Questions Regarding Strong Antitrust Enforcement

Should antitrust enforcement be strong, preventing organizations from consolidating and exercising too much market power? Should there be strong enforcement against horizontal mergers on the delivery side, such as the hospital mergers? Should there also be strong antitrust enforcement against vertical integration--insurance companies acquiring hospitals and physicians and visa versa?

If there is strong enforcement against providers but not against payers, does that leave providers at a competitive disadvantage? Do they presently lack the countervailing power to negotiate rates with the financing side of the industry? If they lack that power, will non-profit institutions be forced to close, and will hospitals have the capital to continue to support charitable missions and to maintain standards of quality?

If there is strong enforcement, will the marketplace efficiently reduce excess capacity and duplication of services? Or will hospitals close without regard to the needs of the communities in which they reside? Will the need to remain competitive put an untenable burden on hospitals that serve poor communities with higher than average health needs and a disproportionate number of uninsured? Will small and rural communities be able to share the cost of expensive equipment and services in markets that cannot support multiple specialized facilities?

Questions Regarding Lenient Antitrust Enforcement

Should we favor a competitive system with lenient antitrust enforcement? Will hospitals and physicians be more strongly competitive if we allow them to consolidate more easily, or will they acquire sufficient market power to raise prices to consumers and eradicate the advantages of competitive markets? Will more lenient antitrust result in a more efficient allocation of services or will it lead to monopolistic pricing in individual product markets? If antitrust exemptions and safe harbors are created for small markets, will that foreclose the potential of selective contracting to bring competitive pricing to those markets?

Will urban markets be most efficient with a few large competing health networks or will those markets tend toward oligopoly in the long run? Is it most efficient for these networks to provide both the financing and delivery of care, or will that foreclose competition? Will vertically integrated networks change the nature and financial incentives of our traditional health institutions? Who will ultimately control these powerful networks and will they maintain a mission to serve their communities?

Questions Regarding Competitive Managed Care Networks

Is strong or lenient antitrust enforcement under procompetitive systems the only alternative, or should we question the very efficacy of competitive systems? Will non-price or "quality competition" remain an important economic force? Are market problems caused by such factors as insurance and large government payers too widespread for competition to work? Are supply side controls needed to ultimately control cost, or do we need a combination of market incentives and government regulation? Can planning and regulation at either the state or federal level be efficient or is it likely to become an inefficient public bureaucracy?

Should we rely on managed care as the basis of our future health care system? Does managed care provide real efficiencies of production and reductions of cost, or does it shift cost from one entity to another? Is there a price to be paid for cost reductions in terms of

reduced access and quality? If real cost savings exist, who will be the ultimate beneficiary of those savings?

The purpose of this paper has been to raise public awareness of this topic and to identify these specific issues. The stakeholders in the health care industry are necessarily aligned on particular sides of these questions. Legislators are being lobbied by their constituent businesses and institutions. The regulatory agencies are not ordinarily concerned with complex matters involving both social and economic policy. An authoritative and independent body, such as the Council, has an opportunity to provide analytic leadership in this area and to provide insight and direction to those responsible for the formulation of public policy.

APPENDIX

A. DETAILED SUMMARY OF HORIZONTAL MERGER GUIDELINES

Section 3.3 listed the five steps in the analytical process the government utilizes to evaluate horizontal mergers. A summary of each of those five steps is presented in this section.

Define The Geographical and Product Markets and Measure Market Concentration.

In order to measure market concentration, one first has to define the market. The definition of a market has two components, the product market and the geographical market. The guidelines use the "smallest market" principle in arriving at a definition. That is, they attempt to determine the smallest product group and the smallest area in which a hypothetical monopolist could effect a "small but significant and non-transitory increase in price (SSNIP)".[48] "Small but significant," is usually considered to be 5%. Hence, one first hypothesizes the smallest product group and smallest area in which a SSNIP might be effected. If it turns out that there is sufficient competition within that small area (either by product substitution, new entrants, etc.) to defeat the price increase - a slightly larger product market and/or area is hypothesized. This iterative process continues until one can define the smallest area in which there are not enough substitute products or accessible competitors to defeat the increase in price.

For example, suppose you lived in a valley that has two towns and is surrounded by mountains. Your product market is widgets. You might first estimate your geographical market as one of the two towns. However, you find that if you raise the price of widgets in one town, people are willing to acquire widgets from the neighboring town in the valley. If you then estimate that the market is the whole valley, you find that it is too difficult to transport widgets over the mountains, and that even with a 5% price increase almost all the widget business is contained within the valley. Thus, the valley is the smallest geographical market that can sustain the price increase.

How does one go about this process? In the case of product markets, the government has used a fairly easy and blunt measure. The cluster of services offered by short term acute care hospitals has been the defined product market in nearly all cases that have been litigated.[49] This measure is blunt because hospitals offer an extensive variety of services, some of which may have competitors within the geographical market and some of which may not. There have been many arguments whether the ease of applying this measure justifies the inaccuracy. However, there is no question that the government could focus on individual product markets, such as obstetrics or cardiac surgery, if it chose to do so.

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[48]1992 Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) P. 13,104, 1992.

[49]Vita, M., et. al., supra # 37.

The definition of geographical markets is often the most contentious element in an antitrust challenge. The larger the definition of the market, the less concentration will result from a merger. Parties to the merger always argue for a broad market definition, while the government always seeks a narrow one. Hence, much attention is focused on this area, and there has been much criticism of the methodology.

The government uses the Elzinger-Hogarty (EH) Test to define geographical markets. The test seeks to find the smallest area for which little business in the product market is conducted outside the boundaries of that area. The EH test uses two formulas to derive the geographical market:

1. Little in from outside (LIFO)

   Total value of services that are both locally produced and consumed / Total local consumption

2. Little out from inside (LOFI)

   Total value of services that are both locally produced and consumed / Total local production

The larger the value of LIFO and LOFI, the less goods are brought over the hypothetical geographic boundary. Values of approximately 90% usually define a geographical market. If either value falls below 75%, a larger market will likely be hypothesized.[50] Market participants include firms that are likely to enter the market within one year and that do not bear significant sunk costs for entry and exit.

The application of the EH test to the health industry has been questioned. It is commonly believed that consumers are willing to travel farther for a complex medical procedure than for ordinary primary care. The EH test does not distinguish between primary and tertiary care or among many specialized or complex procedures. Patients may be subject to SSNIP within their primary care markets even though they would travel out of that market for tertiary care. Hence, a market size specified by the EH test based on flows of tertiary care patients may overstate the size of the primary care market. On the other hand, the EH test may specify a small market in cases where price competition has not previously occurred and where regional prices have been uniform. If price competition were to occur, patients might respond to the incentive to cross previous boundaries. The EH test yields a static picture of the marketplace and is not informative as to how the market would respond to price increases or to collusion.

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[50]Vita, M., et. al., supra #36

Zwanziger argues that application of the EH test tends to identify rural areas as concentrated markets and urban areas as unconcentrated. The result of this is a tendency to enforce strict antitrust in rural markets where there may be little price competition and to allow merger activity in highly competitive markets which may eventually erode the ability of selective contracting to reduce prices[51].

Once the product and geographical markets have been defined, the government uses the Herfindahl-Hirschman Index (HHI) to measure the degree of market concentration. The HHI index is calculated as follows:

- Determine the market share for each firm
- Calculate the square of the market share for each firm
- The absolute HHI index is equal to the sum of the squares, and the change in the index is equal to the difference in the absolute indices before and after the merger.

Hence, if 5 hospitals each controlled 20% of a market, the HHI index would be $(20)^2 + (20)^2 + (20)^2 + (20)^2 + (20)^2 = 2{,}000$. A merger resulting in 4 hospitals, all else being equal, would result in an index of $(25)^2 \times 4 = 2{,}500$, an increase of 500 points.

The government's merger guidelines specify that in cases in which the HHI increases by more than 100 points to a post-merger HHI exceeding 1,800, it will raise significant competitive concerns. These concerns may be counteracted by such factors as the likelihood of new entry, potential efficiencies, and the likelihood that one of the merging entities would fail without the merger.

Given the method of computation above, virtually all communities with 6 or fewer hospitals would be classified as highly concentrated (above 1,800). Hence, in over 80% of U.S. communities that have more than one hospital, any merger would raise significant competitive concerns. The use of the HHI index in hospital markets has frequently been criticized because it classifies so many hospital markets as highly concentrated that it fails to make distinctions among most hospital merger cases.

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[51]Zwanziger Jack, "Antitrust Considerations and Hospital Markets'"*Journal of Health Economics,* 457, 1989; and Zwanziger, Jack, Melnick, Glenn, and Eyre, Kathleen M., "Hospitals and Antitrust: Defining Markets, Setting Standards," 19, *Journal of Health Policy and Law,* Summer 1994.

Senator Hatch addressed this question to James Egan, the Director for Litigation in the Bureau of Competition at the FTC in hearings on May 7, 1993.[52] Mr. Egan responded that the HHI index is a first step, and if the index exceeds the government guidelines, then the qualitative measures 2-5 in the merger guideline process are then considered. Mr. Egan stated:

> "A review of the past Commission investigations of hospital mergers does not suggest a need for concentration standards different than those discussed above to analyze hospital mergers and acquisitions."

If the measure of concentration suggests that a firm may be able to exercise market power, the next step in the process is to ascertain the potential anti-competitive effects.

Assess the Potential Anti-competitive Effects

The guidelines are based on the supposition that if the market is concentrated (i.e. the HHI index is above 1,800), it is prone to anti-competitive actions. The government defines anticompetitive effects as actions involving collusive or unilateral behavior.

The ability to exercise unilateral market power depends on such elements as market share, the elasticity of demand, the elasticity of supply, substitutability and barriers to entry. The subject of entry is considered separately under the guidelines. Unilateral power is sometimes characterized by a dominant firm in a competitive market that competes with small firms that are "price takers" and which do not have the power to increase production and drive back a price increase.

Collusive behavior may occur when there is no single firm that is strong enough to exercise market power, but a small number of large firms can behave anti-competitively by considering the likely actions of their rivals. This may occur simply by firms replicating their rivals price increases rather than keeping their price low and striving for greater volume. The government looks for situations where a merger might bring about sustained collusive behavior. The 1992 guidelines specify 3 elements that indicate the potential likelihood of such behavior:

1. The potential to coordinate prices at profitable levels

2. The ability to detect individual deviations from those prices

3. The ability to punish deviations

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[52]Hearing before the Subcommittee on Medicare and Long-Term Care, Committee on Finance, United States Senate, May 7, 1993.

Punishing deviations may simply entail an action by the other firms to likewise deviate from the coordinated price. If the government concludes that anticompetitive effects are unlikely, it will not be apt to challenge the merger. If it finds that there is a potential for anti-competitive effects, then the next step is to determine whether new market entrants are likely to counteract those effects.

Assess Whether New Entries into the Market Will Counteract Anti-Competitive Effects.

Unless there are barriers to entry, traditional economic theory dictates that anti-competitive behavior will be eroded by new firms that enter a market, supply product, and force prices back down to competitive levels. In health markets, however, a variety of entry barriers may be present. These include large capital requirements, construction lead times, scale economies, scope economies, sunk costs not recoverable upon exit, and government regulation of new entrants through certificate of need requirements.

The government will consider these barriers in conducting a 3 part test for market entry. Those 3 parts are timeliness, likelihood, and sufficiency. In the case of timeliness, the government will consider entry that "can be achieved within two years of initial planning to significant market impact."[53] This is often a significant barrier in hospital cases because of the length of time required to plan, finance and build a hospital and because of potential permitting and certificate of need requirements. Likelihood is determined by whether or not entry will be profitable at pre-merger prices. An entry will be deemed sufficient if it can achieve sufficient output at the competitive price to negate the previous anti-competitive behavior.

If it is determined that the potential for new entrants satisfies these standards, no further analysis is necessary and a merger will not be challenged. If entry is not timely, likely and sufficient, the government will look to the potential efficiencies to be gained from the merger.

Analyze Efficiencies to Determine Whether Efficiencies Gained Outweigh the Anti-competitive Consequences.

If the government determines that the potential efficiencies derived from a merger outweigh any anti-competitive effects, then it will be unlikely to proceed with a challenge.
The greater the potential for anti-competitive behavior, the greater the efficiencies will have to be to counteract them. Arguments for efficiencies have been examined very critically and must satisfy a number of criteria which are specified below.

When the agencies refer to efficiencies, they mean net efficiencies. That is, the cost saving benefits are weighed against offsetting expenditures and potential decreases in quality. For

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[53]1992 Horizontal Merger Guidelines, Supra # 48

example, if the savings from closing a hospital are more than offset by the capital expenditures necessary to consolidate services in the surviving hospital, there will negative, not positive, net efficiencies. The Director of the Bureau of Competition of the FTC used the following example in regard to net efficiency when she stated:

> "In some cases, however, doctors and their patients may incur significant inconveniences or other costs as a result of the consolidation."[54]

She then referred to an acquisition of a hospital in Punta Gorda, Florida by Columbia Hospital Corporation:[55]

> "Less mobile residents of Punta Gorda would be seriously inconvenienced as would Punta Gorda doctors who would either have to relocate their offices or spend more time in transit..."[56]

Significantly, the government indicates in this case that it considers matters of access to health care. These matters could involve a complex range of health policy issues.

Not only do the existence of net efficiencies have to be demonstrated, but it must be shown that those efficiencies will be passed on to consumers in the form of lower quality adjusted prices. The higher the potential for monopolistic behavior, the more likely that proceeds from efficiencies will be retained, and the stronger evidence of potential benefit will be required.

It must also be demonstrated that the efficiencies cannot be accomplished by any other means that have less anti-competitive consequences. Hence, the agencies will examine whether a merger had to occur within the same market, or whether a joint venture in a particular area might accomplish similar efficiencies as a complete merger. The government has issued consent decrees for contractual arrangements short of proposed mergers, that forth conditions to which the parties must adhere in any collaboration.

There are various kinds of efficiencies that may result from collaborative ventures. They include savings from closing or consolidating departments, facilities or services, economies of scale, economies of scope, and administrative efficiencies. Efficiencies through consolidation tend to be the most classic arguments. Economies of scale are discussed briefly in section 2.5.1. Most of the hospital merger cases have involved hospitals which are

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[54]Steptoe, Mary Lou, "Efficiency Justifications for Hospital Mergers," Remarks before the Practicing Law Institute, San Francisco, CA, 6/17/94 and New York, NY, 7/20/94.

[55]FTC v. Columbia Hospital Corp., 1993-1 Trade Cas. (CCH) p. 70,209 (M.D. Fla. 1993)

[56]Steptoe, May Lou, supra #54

above the size in which economies of scale would have a significant effect. Hence, it has been difficult for most merging parties to sustain a defense based solely on that rationale. Administrative efficiencies tend to be difficult to prove and to be relatively small in dollar amounts.

It is important to note, that while efficiency defenses have been successful in individual cases, the burden of proof is certainly on the collaborating parties. On the other hand, the agencies take account of efficiency arguments in deciding upon which cases to challenge and may place more weight upon these arguments than the court. Mary Lou Steptoe remarked:

> "...efficiency arguments are more clearly relevant to the commission in exercising its prosecutorial discretion, than to litigation before a federal or administrative court judge."[57]

Consider a Failing Firm Defense

The government will recognize a defense based upon the rationale that absent the merger, at least one of the merging entities would both fail and exit the market. The government specifies four requirements for a valid defense of this nature:

1. Absent the merger an imminent business failure would occur

2. There is an inability to reorganize in bankruptcy

3. There are no reasonable offers from alternative purchasers

4. The assets of the failing firm would exit the relevant market

The government further specifies that any offer that is greater than the liquidation value of the firms assets constitutes a reasonable offer from an alternative purchaser.

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[57]Steptoe, Mary Lou, supra # 54

B. DETAILED SUMMARY OF ANTITRUST ENFORCEMENT POLICY STATEMENTS

In September, 1994 the FTC and the DOJ issued Antitrust Enforcement Policy Statements in nine specific areas of collaborative activity. These were listed in Section 3.4. Some of these statements specify "antitrust safety zones." The government has stated that it will not challenge activities that fall within these safety zones unless there are extraordinary circumstances. These safety zones only offer administrative protection from the actions of these agencies, however, and to not have bearing on court proceedings or private third party lawsuits. A summary of each of these statements is presented below.

1. Mergers Among Hospitals

An antitrust safety zone is provided for small hospital mergers. To qualify, at least one of the hospitals has to have an average of less than 100 licensed beds over the past three years, have an average inpatient census of less than 40 over the past three years, and be at least five years old. Mergers that fall outside the safety zone are subject to the rule of reason analysis summarized in Appendix "A".

2. Hospital Joint Ventures Involving High Technology or Other Expensive Health Care Equipment

An antitrust safety zone is provided for a legitimate joint venture in which hospitals purchase or share the ownership of, operate, and market the related services of high technology or other expensive equipment. This equipment can be new or existing. The joint venture must include only the number of hospitals needed to support the equipment. Supporting the equipment is defined as recovering the costs of owning, operating and marketing (as appropriate to the agreement) over the useful life of the equipment. The joint venture may include additional hospitals if those additional hospitals could not support the equipment on their own or through a competing joint venture.

Joint ventures of this nature which fall outside of the safety zone will be decided by a rule of reason approach. That approach will determine whether the venture will reduce competition substantially and, if it will, whether the expected procompetitive efficiencies outweigh the anticompetitive potential. The agencies specify four steps in the rule of reason analysis:

1. Define the relevant market
2. Evaluate the competitive effects of the venture
3. Evaluate the impact of procompetitive efficiencies
4. Evaluate collateral agreements

Agreements which purport to be joint ventures, but are only "sham joint ventures" or agreements to fix prices or decrease output are illegal per se. A distinction must be made between legitimate ventures that fall outside the safety zone and "sham" ventures that are per

se illegal. It is important to note that the government has never challenged a legitimate joint venture in the health care industry.

3. Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Health Care Services

The government has not provided a safety zone because it claims a lack of experience in evaluating joint ventures of this nature. The government will employ a rule of reason analysis to evaluate such ventures which will be comprised of the same four steps specified in number two, above.

4. Provider's Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services

An antitrust safety zone is provided for the collective provision by providers of the following kinds of non-fee-related information: Underlying medical data about the mode, quality, or efficiency of treatment (including outcome data), and development of suggested practice parameters. Providers can also engage in collective discussions regarding the scientific merit of underlying medical data. The statement explicitly warns against attempts to imply or threaten a collective boycott or to refuse to deal with prospective purchasers.

5. Providers Collective Provision of Fee-related Information to Purchasers of Health Care Services

An antitrust safety zone is provided for the collective provision of current and historical fee-related information if it satisfies the following conditions:

a. The collection of information is managed by a third party
b. Information shared among competing providers must be more than three months old. Current fee-related information may be provided to purchasers, but cannot be shared among competing providers.
c. For information shared by competing providers there must be at least five providers reporting on each kind of data and no one provider's data can represent more than 25%, on a weighted basis, of that statistic. Such data must be sufficiently aggregated so that prices charged by individual providers cannot be deduced.

The government has explicitly excluded from the safety zone collective negotiations between unintegrated providers and purchasers in order to set terms or reimbursement rates. The government also explicitly warns against implied or actual boycotts or similar conduct to coerce the acceptance of collectively determined fees.

The government has also excluded prospective fee related matters stating that those will be assessed on a case-by-case basis. In such cases, the agencies will consider the facts and

circumstances surrounding the provision of information, the nature of the information provided and the communications that occurred, the rationale for providing the information, and the nature of the market in which the information is provided.

6. Provider Participation in Exchanges of Price and Cost Information

An antitrust safety zone is designated for providers that participate in written surveys of prices of health care services or wages, salaries and benefits of health care personnel subject to the following conditions:

a. The survey is managed by a third party
b. The information provided is more than 3 months old
c. There must be at least five providers reporting on each kind of data and no one provider's data can represent more than 25%, on a weighted basis, of that statistic. Such data must be sufficiently aggregated so that prices charged or compensation paid by individual providers cannot be deduced.

Agreements to provide surveys of this nature that fall outside of the safety zone will be evaluated to determine if the information may have an anticompetitive effect that outweighs any procompetitive justification. The government explicitly warns that surveys involving future prices are very likely to be considered anticompetitive.

7. Joint Purchasing Agreements Among Health Care Providers

An antitrust safety zone is provided for joint purchasing arrangements among health care providers subject to the following conditions:

a. The purchases account for less than 35% of total purchases in the relevant product and geographic market.
b. The cost of the jointly purchased items or services account for less than 20% of the total revenue from all items or services sold by each competing participant.

For joint purchasing agreements falling outside the safety zone, the government has enumerated three factors that will reduce antitrust concerns:

a. Members are not required to use the arrangement for all purchases of a particular product or service.
b. Negotiations are conducted by a third party
c. Communications between the purchasing group and individual participants are kept confidential from other members of the group.

If the government finds that there are substantial efficiencies to be gained by a joint purchasing agreement, it will not challenge unless there is also a substantial risk of

anticompetitive effects. In most cases, these agreements do not have to be opened up to all competitors in a market. However, if competitors are unable to compete effectively without access to the arrangement, then antitrust concerns will arise.

8. Physician Network Joint Ventures

The agencies define a physician joint network as "a physician controlled venture in which the member physicians collectively agree on prices or other significant terms of competition and jointly market their services." This statement applies to these specific kinds of joint ventures only, and does not apply to multi-provider networks or agreements not involving prices or other significant terms of competition.

The agencies further define physician joint networks as being either "exclusive" or "non-exclusive." Exclusivity refers to whether the arrangement significantly affects the ability of member physicians to contract outside of the proposed venture.

Antitrust safety zones are provided for exclusive and non-exclusive physician joint networks subject to the following conditions:

a. Exclusive joint ventures must comprise no more than 20% of the physicians in each specialty who have active hospital privileges, who practice in the relevant geographic market and who share substantial risk. If a market has fewer than 5 physicians in a particular specialty, a venture that satisfies all other conditions can contract with one of those specialists, even if his or her market share exceeds 20%.

b. Non-exclusive joint ventures must comprise no more than 30% of the physicians in each specialty who have active hospital privileges, who practice in the relevant geographic market and who share substantial risk. If a market has fewer than 4 physicians in a particular specialty, a venture that satisfies all other conditions can contract with one of those specialists, even if his or her market share exceeds 30%.

The agencies will judge exclusivity not only by contract specifications, but also by the following factors:

a. Viable competing plans with adequate provider participation exist in the market.
b. Providers in the network actually perform services outside the network, or there is evidence of their willingness and incentive to do so.
c. Providers in the network earn substantial revenue outside the network.
d. There is no evidence of reduced participation outside the network.
e. There is no indication of collective behavior among members regarding pricing or other significant terms of participation outside the network.

The agencies will judge the sharing of substantial financial risk according to the following attributes:

a. The venture contracts with plans to provide services at a capitated rate.
b. The venture creates significant financial incentives for cost containment such as financial "withholds" and other incentive methods.

Physician network joint ventures falling outside the safety zone, will be judged by a rule of reason analysis (as opposed to being per se illegal) if they either share substantial financial risk or if the venture offers a new product that produces substantial efficiencies. The rule of reason analysis is the same as that in statements two and three and consists of the following:

a. Define the relevant market
b. Evaluate the competitive effects of the venture
c. Evaluate the impact of procompetitive efficiencies
d. Evaluate collateral agreements

9. Analytical Principles Relating to Multiprovider Networks

The agencies define multiprovider networks as "ventures among providers that jointly market their services to health benefit plans and other purchasers." The agencies state that because of their lack of experience with multiprovider networks they are not specifying safety zones or formal statements of policy. Rather they are elucidating the principles by which they intend to analyze these cases.

If multiprovider networks involve agreements that restrict competition, the agencies will determine if those agreements are per se violations of the antitrust statutes or if they should be judged by a rule of reason analysis. In order to be judged by a rule of reason analysis the following conditions must be satisfied:

a. Competitors make unilateral decisions on prices and allocation. This may be accomplished by a "messenger model" wherein a third party negotiates with purchasers on behalf of individual network participants and that party makes individual decisions without being influenced by the negotiations of other parties in the network.

b: There is sufficient economic integration among network participants. Sufficient economic integration is evidenced by substantial sharing of financial risk. Examples of financial risk sharing were presented in statement #8 above.

In the case of joint pricing and marketing activity, members of the network must not only share substantial financial risk but the competitive restrictions must be "reasonably necessary to achieve the efficiencies sought by the venture."

A rule of reason analysis will consist of the following process:

a. Market definition - Product markets may include markets for competing networks, but also may be broken down onto markets for each specialty. Geographical markets may vary with each product market.

b. Competitive effects - the agency will examine both horizontal and vertical competitive effects. Horizontal effects will be analyzed according to the horizontal merger guidelines explained in detail in Section 3.3.2. In evaluating horizontal effects, the agencies will consider exclusivity and the ability of third party payers to switch between networks or providers in response to a price increase.

   Vertical effects will be analyzed to ascertain whether the network will "foreclose competition by impeding the formation and operation of competing networks." In evaluating the foreclosure of competition, the agencies will consider exclusivity, the ability of third party payers to switch between networks or providers in response to a price increase, and whether or not there are enough competing physicians to allow new networks to form. Exclusivity is examined according to the same criteria specified in statement #8 above.

c. Exclusion of particular providers - A rule of reason analysis is employed to determine if the exclusion of providers from the network "reduces competition among providers in the market and thereby harms consumers."

d. Efficiencies - The agencies will balance anticompetitive effects with potential net efficiencies.

e. Information used in the analysis - The agencies explicitly state that they will utilize information garnered from interviews with people familiar with the particular market. These may include health plans, purchasers of services, employers and others. Particular attention is given to the ability of purchasers to switch between providers in response to an increase in price.