

EXECUTIVE SUMMARY

Health care is a vital service that daily touches the lives of millions of Americans at significant and vulnerable times: birth, illness, and death. In recent decades, technology, pharmaceuticals, and know-how have substantially improved how care is delivered and the prospects for recovery. American markets for innovation in pharmaceuticals and medical devices are second to none. The miracles of modern medicine have become almost commonplace. At its best, American health care is *the* best in the world.

Notwithstanding these extraordinary achievements, the cost, quality, and accessibility of American health care have become major legislative and policy issues. Substantial increases in the cost of health care have placed considerable stress on federal, state, and household budgets, as well as the employment-based health insurance system. Health care quality varies widely, even after controlling for cost, source of payment, and patient preferences. Many Americans lack health insurance coverage at some point during any given year. The costs of providing uncompensated care are a substantial burden for many health care providers, other consumers, and tax payers.

This Report examines the role of competition in addressing these challenges. The proper role of competition in health care markets has long been debated. For much of our history, federal and state regulators, judges, and academic commentators saw health care as a “special” good to which normal economic forces did not apply. Skepticism about the role of competition in health care continues.

This Report by the Federal Trade Commission (Commission) and the Antitrust Division of the Department of Justice (Division) (together, the Agencies) represents our response to such skepticism. In the past few decades, competition has profoundly altered the institutional and structural arrangements through which health care is financed and delivered. Competition law and policy have played an important and beneficial role in this transformation. Imperfections in the health care system have impeded competition from reaching its full potential. These imperfections are discussed in this Report.

The Agencies based this Report on 27 days of Joint Hearings from February through October, 2003; a Commission-sponsored workshop in September, 2002; and independent research. The Hearings broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Hearings gathered testimony from approximately 250 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. The Hearings and Workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the Hearings and Workshop and all written submissions are available on the Commission website.

The Report addresses two basic questions. First, what is the current role of competition in health care, and how can it be

enhanced to increase consumer welfare? Second, how has, and how should, antitrust enforcement work to protect existing and potential competition in health care?

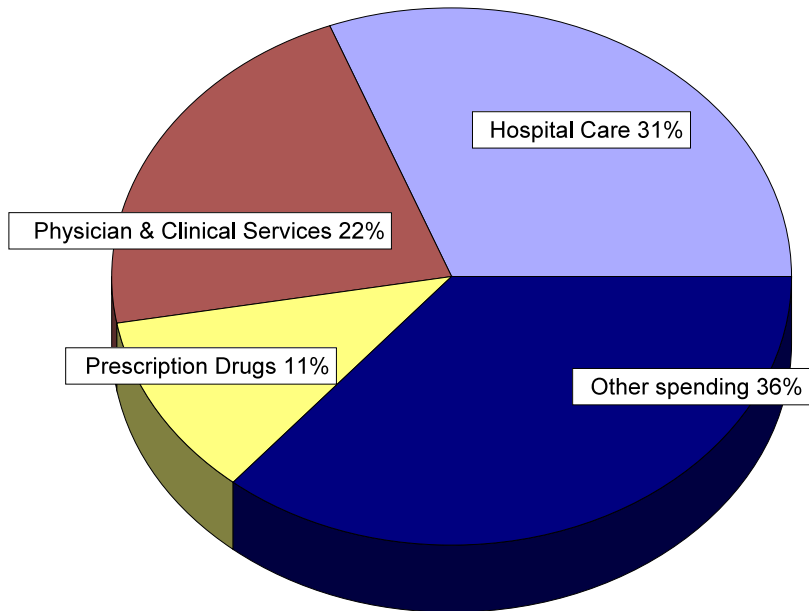
This Executive Summary outlines the Agencies' research, findings, conclusions, recommendations, and observations. Subsequent chapters provide in-depth discussion and analyses. Chapter 1 provides an overview and introduction. Chapter 2 focuses on physicians. Chapters 3 and 4 address hospitals. Chapters 5 and 6 consider insurance. Chapter 7 focuses on pharmaceuticals. Chapter 8 addresses a range of issues, including certificate of need, state action, long-term care, international perspectives, and remedies. We begin with a review of why health care issues are so important.

I. CURRENT HEALTH CARE CHALLENGES

A. *Health Care Expenditures Are Once Again Rising Dramatically*

Health care spending in the United States far exceeds that of other countries. Approximately 14% of gross domestic product, or \$1.6 trillion in 2002, is spent on health care services in the United States. Federal, state, and local governments pay for approximately 45 percent of total U.S. expenditures on health care; private insurance and other private spending account for 40 percent; and consumer out-of-

Figure 1: Total Health Care Spending



pocket spending accounts for the remaining 15 percent.

As Figure 1 reflects, in 2002, 31 percent of the \$1.6 trillion spent by Americans on health care went to inpatient hospital care; that percentage has declined substantially over the past twenty years, as hospitalization rates and lengths of stay have declined. Physician and clinical services account for 22 percent, but physicians' decisions and recommendations affect a far larger percentage of total expenditures on health care. Prescription drugs account for about 11 percent; that percentage has increased substantially over the past decade. The remaining 36 percent is split among long-term care, administrative, and other expenditures.

The percentage of gross domestic product spent on health care rose substantially during the 1970s and 1980s,

but stabilized during most of the 1990s at around 13.5 percent. In the last few years, however, dramatic cost increases have returned, attributable to both increased use of and increased prices for health care services. Inpatient hospital care and pharmaceuticals are the key drivers of recent increases in expenditures. These trends are likely to continue – and even accelerate – as new technologies are developed and the percentage of the population that is elderly increases.

B. Health Care Quality Varies

Quality has multiple attributes. Many health services researchers and providers focus on whether the care that is provided is based on empirical evidence of efficacy. The Institute of Medicine defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The Agency for Healthcare Research and Quality defines quality health care as “doing the right thing at the right time in the right way for the right person and having the best results possible.” Some consumers may focus on how long they must wait for an appointment, and how they are treated at the provider’s office. Many health care providers and health services researchers treat the cost of care (and the resources of consumers) as immaterial; for them, you either provide high quality care to a particular patient or disease set, or you do not.

From a consumer perspective, health care quality encompasses several distinct

factors, and the delivery system must perform well on each if it is to provide high quality care. These factors include whether the diagnosis is correct, whether the “right” treatment is selected (with the “right” treatment varying, depending on the underlying diagnosis and patient preferences), whether the treatment is performed in a technically competent manner, whether service quality is adequate, and whether consumers can access the care they desire. Information is necessary for consumers to make decisions regarding their care, and determine how well the health care system is meeting their needs.

If we focus strictly on technical measures, what is known about the quality of health care in the United States? Commentators and panelists agree that the vast majority of patients receive the care they need, but there is still significant room for improvement. Commentators and panelists note that treatment patterns vary significantly; procedures of known value are omitted, and treatments that are unnecessary and inefficacious are performed and tens of billions of dollars are spent annually on services whose value is questionable or non-existent. As one commentator stated, “quality problems . . . abound in American medicine. The majority of these problems are not rare, unpredictable, or inevitable concomitants of the delivery of complex, modern health care. Rather, they are frighteningly common, often predictable, and frequently preventable.”¹

¹ Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 566 (1998).

C. *The U.S. Economy Typically Relies on Market Competition*

In the overwhelming majority of markets, the government does not decide the prices and quality at which sellers offer goods and services. Rather, rivals compete to satisfy consumer demand, and consumers make decisions about the price and quality of goods or services they will purchase. A well-functioning market maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives.

Vigorous competition, both price and non-price, can have important benefits in health care as well. Price competition generally results in lower prices and, thus, broader access to health care products and services. Non-price competition can promote higher quality and encourage innovation. More concretely, competition can result in new and improved drugs, cheaper generic alternatives to branded drugs, treatments with less pain and fewer side effects, and treatments offered in a manner and location consumers desire. Vigorous competition can be quite unpleasant for competitors, however. Indeed, competition can be ruthless – a circumstance that can create cognitive dissonance for providers who prefer to focus on the necessity for trust and the importance of compassion in the delivery of health care services. Yet, the fact that competition creates winners and losers can inspire health care providers to do a better job for consumers. Vigorous competition promotes the delivery of high quality, cost-effective health care, and vigorous antitrust enforcement helps protect competition.

At the same time, competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them. The next section identifies some of the features of health care markets that can limit the effectiveness of competition.

II. FEATURES OF HEALTH CARE MARKETS THAT CAN LIMIT COMPETITION

A. *The Health Care Marketplace is Extensively Regulated*

An extensive regulatory framework, developed over decades, at both the federal and state levels of government affects where and how competition takes place in health care markets. Much of the regulatory framework arose haphazardly, with little consideration of how the pieces fit together, or how the pieces could exacerbate anticompetitive tendencies of the overall structure. Proposals for new regulatory interventions have often focused solely on their claimed benefits, instead of considering their likely costs, where proposals fit into the larger regulatory framework, and whether proposals frustrate competition unnecessarily. Failure to consider such matters can reinforce existing regulatory imperfections and reward incumbent interests. Indeed, in health care, some commentators see competition as a problem to be tamed with top-down prescriptive

regulations, instead of an opportunity to improve quality, efficiency, and enhance consumer welfare.

As a significant purchaser in most health care markets, the government uses regulations to influence the price and quality of the services for which it pays. The government's actions as both purchaser and regulator have profound effects on the rest of the health care financing and delivery markets as well. Price regulation, even if indirect, can distort provider responses to consumer demand and restrict consumer access to health care services. Regulatory rules also can reduce the rewards from innovation and sometimes create perverse incentives, rewarding inefficient conduct and poor results. Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition. The scope and depth of regulation is also not universal; providers offering competing services are routinely subject to widely varying regulatory regimes and payment schedules.

B. Third-Party Payment Can Distort Incentives

Health insurance shifts and pools the risks associated with ill health. By providing greater predictability, health insurance protects the ill and their families from financial catastrophe. Nonetheless, third-party payment of health-related expenses can distort incentives and have unintended consequences.

Consumer Incentives. Insured consumers are insulated from most of the costs of their decisions on health care treatments. The result is that insured consumers have limited incentive to balance costs and benefits and search for lower cost health care with the level of quality that they prefer. A lack of good information also hampers consumers' ability to evaluate the quality of the health care they receive.

Provider Incentives. Panelists and commentators agreed that providers have a strong ethical obligation to deliver high quality care. The health care financing system, however, generally does not directly reward or punish health care providers based on their performance. When this fact is coupled with the consumer incentives outlined above, the result is that providers who deliver higher quality care are generally not directly rewarded for their superior performance; providers who deliver lower quality care are generally not directly punished for their poorer performance and, worse still, may even be rewarded with higher payments than providers who deliver higher quality care.

Payor Incentives. Insurers generally offer coverage terms tied to professionally dictated standards of care, restricting the range of choices and trade-offs that consumers may desire. Insurers aggregate consumer preferences, but there can be incentive mismatches because insurers generally bear the costs but do not capture the full benefits of coverage decisions and because insurance contracts have a defined term (usually annually) that is generally shorter than the period of interest to the consumer.

C. *Information Problems Can Limit the Effectiveness of Competition*

The Lack of Reliable and Accurate Information about Price and Quality. The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods and services, although numerous states and private entities are experimenting with a range of “report cards” and other strategies for disseminating information to consumers. Without good information, consumers have more difficulty identifying and obtaining the goods and services they desire.

The Asymmetry of Information between Providers and Consumers. Most consumers have limited information about their illness and their treatment options. Consumers with chronic illnesses have more opportunity and incentive to gather such information, but there is still a fundamental informational asymmetry between providers and patients. There is also considerable uncertainty about the optimal course of treatment for many illnesses, given diverse patient preferences and the state of scientific knowledge.

Consumer Uncertainty about Reliability of Health Care Information. Uncertainty increases transaction costs, fraud, and deception dramatically. Although the Internet can provide access to information about health care, it also enhances the risks of fraud and deception regarding “snake oil” and miracle cures.

Information Technology. Health care does not employ information technology

extensively or effectively. Prescriptions and physician orders are frequently hand-written. Records are often maintained in hard copy and scattered among multiple locations. Few providers use e-mail to communicate with consumers. Public and private entities have worked to develop and introduce electronic medical records and computerized physician order entry, but commentators and panelists agreed that much remains to be done.

D. *Cost, Quality, and Access: The Iron Triangle of Trade-offs*

Health policy analysts commonly refer to an “iron triangle” of health care.² The three vertices of the triangle are the cost, quality, and accessibility of care. The “iron triangle” means that, in equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on health care.

Such tradeoffs are not always required, of course. For example, tying payments to health care providers to the quality of services provided could improve providers’ incentives to contain costs and improve quality. Better quality also could be achieved at less cost by reducing unnecessary services and managing consumers with chronic conditions more cost-effectively. Competition has an important role to play in accomplishing these objectives.

² WILLIAM L. KISSICK, MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES (1994).

Nonetheless, trade-offs among cost, quality, and access can be necessary. Those trade-offs must be made at multiple levels by multiple parties. Some consumers may prefer a “nothing but the best” package of medical care, but others are willing to trade-off certain attributes of quality for lower cost, or trade-off one attribute of quality for another. For example, some consumers will be more willing than others to travel in exchange for lower prices, while others may be more willing to travel in exchange for higher quality care. Good information about the costs and consequences of each of these choices is important for competition to be effective.

E. Societal Attitudes Regarding Medical Care

For most products, consumers’ resources constrain their demand. Consumers and the general public do not generally expect vendors to provide services to those who cannot pay for them. Few would require grocery stores to provide free food to the hungry or landlords to provide free shelter to the homeless. By contrast, many members of the public and many health care providers view health care as a “special” good, not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay. Similarly, many perceive risk-based premiums for health insurance to be inconsistent with obligational norms and fundamental fairness, because those with the highest anticipated medical bills will pay the highest premiums. A range of regulatory interventions reflect these norms.

F. Agency Relationships

A large majority of consumers purchase health care through multiple agents – their employers, the plans or insurers chosen by their employers, and providers who guide patient choice through referrals and selection of treatments. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests.

III. HOW THE HEALTH CARE MARKETPLACE CURRENTLY OPERATES

Competitive pressures for cost containment have spurred the development of new forms of health care financing and delivery. Government payors have adopted new forms of payments for health care providers to slow health care inflation. Private payors have adopted systems, such as managed care and preferred provider organizations, to encourage or require consumers to choose relatively lower-cost health care. Physicians have tried new types of joint ventures and consolidation, and hospitals have consolidated through merger and the creation of multi-hospital networks. These new organizational forms offer the potential for reducing costs and increasing provider bargaining power. More recently, strategies for improving the quality of health care have gained attention. Health care markets remain in flux.

A. *How Consumers Pay for Health Care*

Most Americans pay for health care through health insurance. Most Americans under the age of 65 obtain health insurance through their employer or the employer of a family member. Some Americans under the age of 65 obtain coverage through a government program or purchase an individual insurance policy. Americans aged 65 and over are almost always covered by Medicare. In 2002, the Census Bureau estimated that approximately 85 percent of the total U.S. population had health insurance coverage.

1. Publicly Funded Programs

Medicare. Medicare provides coverage for approximately 40 million elderly and disabled Americans. Medicare Part A covers most Americans over 65, and provides hospital insurance coverage. Although Medicare Part B is optional, almost all eligible parties enroll, given substantial federal subsidies to the program. Medicare Part B provides supplementary medical coverage for, among other things, doctors' visits and diagnostic tests. Many Medicare beneficiaries also purchase Medicare Supplemental Insurance (Medigap) policies or have coverage from a former employer. Medigap policies are federally regulated and must include specified core benefits.

In 1997, Congress enacted Medicare + Choice (M+C). M+C encouraged Medicare beneficiaries to join privately operated managed care plans, which often offer greater benefits (*e.g.*, prescription drug coverage) in exchange for accepting limits

on choice of providers. In 2003, Congress renamed M+C Medicare Advantage, and enacted prescription drug benefits for Medicare beneficiaries.

Medicaid. Medicaid provides coverage for approximately 50 million Americans. Although the federal government sets eligibility and service parameters for the Medicaid program, the states specify the services they will offer and the eligibility requirements for enrollees. Medicaid programs generally cover young children and pregnant women whose family income is at or below 133 percent of the federal poverty level, as well as many low-income adults. Most states have most of their Medicaid population in some form of managed care. Medicaid pays for a majority of long term care in the United States.

Payments to Health Care Providers: Past and Present. Prior to 1983, Medicare, as well as most other insurers, reimbursed providers under a "fee-for-service" (FFS) system based on the costs of the number and type of services performed. Despite some restraints on how much a provider could claim as its costs, the result was to reward volume and discourage efficiency. Commentators argued that the combination of FFS payment, health insurance, and consumers' imperfect information about health care created incentives for providers to provide, and consumers to consume, greater health care resources than would be the case in competitive markets. In addition, FFS payment dampened the potential for effective price competition, because FFS guaranteed reimbursement for claimed charges. Thus, providers lacked incentives to lower prices.

Hospitals and Ancillary Services. In response to increasing health care expenditures, Congress directed the Center for Medicare and Medicaid Services (CMS) to adopt the inpatient prospective payment system (IPPS) as a means to create a more competitive, market-like environment for hospital reimbursement by Medicare. The IPPS took effect in 1983. The diagnosis-related group (DRG) for the diagnosis at discharge determines the amount that the hospital is paid. Each DRG has a payment weight assigned to it, which reflects the average cost of treating patients in that DRG. Hospitals receive this predetermined amount regardless of the actual cost of care, although adjustments are made for extraordinarily high-cost cases (“outlier payments”), teaching hospitals, and hospitals that serve a disproportionate number of low-income patients.

Similarly, Congress directed CMS to change its payment system for hospital-based outpatient care provided to Medicare beneficiaries. On August 1, 2000, the payment system changed from a cost-based system to the outpatient prospective payment system (OPPS), under which CMS reimburses hospitals based on one of about 750 ambulatory payment classifications (APCs) in which an episode of care falls. Each APC has a general weight based on the median cost of providing the service.

Congress also directed CMS to adopt prospective payment systems for skilled nursing facilities and home health care services, and those systems are currently in effect. As of 2007, Medicare is scheduled to begin a competitive bidding system to determine which providers will offer durable medical equipment to Medicare

beneficiaries.

Both the IPPS and the OPPS have constrained expenditures more effectively than the cost-based systems they replaced. With the introduction of IPPS, the increase in hospital expenditures slowed, and average length of hospital stay declined. The adoption of prospective payment for home health care services also had an immediate impact on the number of beneficiaries that received services and the average number of visits.

Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market.

Physicians. Medicare pays for physician services using the resource-based relative value scale (RBRVS), a system for calculating a physician fee schedule. CMS calculates the fee schedule on the basis of the cost of physician labor, practice overheads and materials, and liability insurance, as adjusted for geographic and yearly differences.

2. Employment-Based Insurance

Employers offer insurance to their employees and retirees through various sources, including commercial insurance companies, employers’ self-funded plans, or various combinations of the two. Employers

that offer health insurance through commercial insurers usually negotiate on behalf of their employees for a package of benefits at a specified monthly premium per person or per family. Some employers choose to self-fund (self-insure) by assuming 100 percent of the risk of expenses from their employees' health care coverage. Some employers create self-insured plans, but contract with commercial insurance companies to act as a third-party administrator for claims processing, for access to a provider network, or to obtain stop-loss coverage. The applicability of federal and state laws and regulations varies, depending on the source of health care coverage an employer makes available to employees and retirees.

Not all employers offer health coverage, and some employers offer coverage only to full-time employees. In some sectors of the economy, employment-based health insurance is less common. The larger the employer, the more likely it is to offer health insurance. Premiums and coverage vary widely. The number of people with employment-based insurance fluctuated throughout the 1990s but has currently stabilized at approximately 61 percent of the U.S. population.

The federal government subsidizes employment-based health insurance through the tax code. Employer contributions for health insurance coverage are deductible to employers, but are not considered taxable income to employees and retirees. The result is that employees can obtain health care coverage through their employer with pre-tax dollars. Although it is common parlance to speak of "employer contributions" to the cost of health care

coverage, employees and retirees ultimately bear these costs in the form of lower salaries and benefits.

Payments to Providers. In some instances, private payors have copied the payment strategies of the Medicare program or have used Medicare payments as a reference price for negotiation with providers. For example, some payors negotiate either a specified discount or a specified premium relative to the payment the Medicare program would make for a specific episode of hospitalization or service. To be sure, many payors do not rely on these strategies, and instead structure their own payment arrangements with providers, including discounted per diem payments to hospitals and negotiated discounts off charges for other providers.

3. Individual Insurance

In 1999, approximately 16 million working-age adults and children – almost 7 percent of the population under 65 – obtained health insurance coverage through individually issued, non-group policies. Commentators suggest that this small market share is due, in part, to the tax subsidies provided for employment-based coverage. Individual insurance policies are generally more expensive and less comprehensive than group policies.

4. The Uninsured

Approximately 15 percent of the population, or 44 millions Americans, lacked health insurance at some point during 2002. A study by the Congressional Budget Office found that 45 percent of the uninsured were without coverage for four

months or less, and that only 16 percent of the uninsured (or approximately 6.9 million Americans) remained so for more than two years. The uninsured are more likely to be younger and less likely to have a regular source of care, less likely to use preventive services, and more likely to delay seeking treatment. Studies indicate a variety of adverse health consequences are associated with being uninsured.

Medical treatment for the uninsured is often more expensive than care of the insured, because the uninsured are more likely to delay treatment and receive care in an emergency room. Hospitals typically bill the uninsured full price for the services they received, instead of the discounted prices that hospitals offer insured patients pursuant to negotiated contracts with their insurers. The uninsured bear some of the costs of treatments themselves and often cannot fully pay for the care they receive. The burden of providing this uncompensated care varies significantly among providers and regions. For example, the burden of uncompensated care is greater in the South and West, where a higher percentage of the population is uninsured, than in the rest of the United States. The costs of uncompensated treatments for the uninsured are either paid by taxpayers, absorbed by providers, or passed on to the insured.

B. How Consumers Receive Health Care: The Rise and Decline of Managed Care

Burgeoning health care expenditures in the 1960s and 1970s led to numerous proposals to provide better incentives to contain costs. Some commentators argued that organizations that agreed to meet the

health care needs of a consumer at a set price for a set period of time offered a solution to this problem. Such prepaid group practices existed in some parts of the United States beginning in the early part of the 20th century, but Congress took a significant step in this direction with passage of the Health Maintenance Organizations Act of 1973 (HMO Act). The HMO Act provided start-up funds to encourage the development of HMOs, overrode State anti-HMO laws, and required large firms to offer an HMO choice to their employees. These forces set the stage for the development of managed care organizations (MCOs). Managed care means different things to different people, and it has meant different things at different times. There is general agreement, however, that MCOs integrate the financing and delivery of health care services, albeit to varying degrees. In global terms, managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and co-payments than traditional indemnity insurance.

MCOs historically relied on three strategies to control costs and enhance quality of care. One is selective contracting with providers that must meet certain criteria to be included in the MCO's provider network. Selective contracting can intensify price competition and allow MCOs to negotiate volume discounts and choose providers based on a range of discounts. When MCOs and other insurers have a credible threat to exclude providers from their networks and send patients elsewhere, providers have a powerful incentive to bid aggressively to be included in the network. Without such credible threats, providers have less incentive to bid aggressively, and

even MCOs with large market shares may have less ability to obtain lower prices.

Another strategy is to use incentives that shift some of the financial risk to providers. Capitation, for example, pays providers a fixed amount for each of the patients for whom they agree to provide care, regardless of whether those patients seek care or the costs of their care exceeds the fixed amount. Some physician groups participating in capitation arrangements underestimated these risks and went bankrupt, and providers have become increasingly reluctant to accept the risks of capitation in recent years. Direct financial incentives for providers in the form of bonuses (or withholding a percentage of payment) based on meeting clinical or financial targets remain fairly prevalent, with considerable variation in their details.

A third strategy is utilization review of proposed treatments and hospitalizations. This strategy involves an appraisal of the appropriateness and medical necessity of the proposed treatment. Many MCOs and other insurers use utilization review in a variety of forms.

In recent years, many MCOs have adopted a fourth strategy: increased cost-sharing. Cost sharing creates direct financial incentives for consumers – through varying co-payments and deductibles – to receive care from particular providers or in particular locations.

By the late 1990s, managed care had grown so unpopular that commentators began to refer to a “managed care backlash.” Providers complained that their clinical judgments were second-guessed; consumers

complained that managed care was restricting choices, limiting access to necessary medical care, and lowering quality. These concerns resulted in a number of federal and state legislative and regulatory initiatives, as well as private litigation against MCOs.

Commentators report a substantial gap between consumer and provider perceptions, on the one hand, and managed care’s actual impact, on the other. They point to surveys and studies showing that consumers are generally satisfied with their own MCOs, that MCOs do not provide poorer quality care than FFS medicine, and that “managed care horror stories” are often exaggerated or highly unrepresentative.

In recent years, more restrictive forms of managed care have been eclipsed by offerings with more choice and flexibility. These offerings include point-of-service (POS) plans, which allow patients to select a primary care gatekeeper, yet use out-of-plan physicians for some services. Preferred provider organizations (PPOs) are similar to POS programs, but generally do not require a coordinating primary care physician. Instead, PPOs have a panel of “preferred providers” who agree to accept discounted fees. Some physicians who wish to avoid managed care entirely have begun “concierge practices,” where they provide personalized care, including house calls, to patients willing and able to pay out of pocket for health care costs.

Public and private payors are also experimenting with payment for performance (P4P) initiatives. Commentators and panelists generally agreed that P4P should be more widely

employed in health care. Many payors have yet to adopt P4P programs, and some providers have resisted such programs. The development of P4P programs will require better measurement of, and information about, health care quality.

IV. HEALTH CARE PROVIDERS: NEW DELIVERY SYSTEMS, NEW FORMS OF ORGANIZATION, AND COMPETITIVE PRESSURES

A. Physicians

Spending on physician services accounts for approximately 22 percent of the \$1.6 trillion spent annually on health care services. Total spending on physician services increased at an average annual rate of 12 percent from 1970-1993, and at 4 to 7 percent a year since then. In response to increased competitive pressures from MCOs and other payors to lower their prices, some physicians have attempted to respond procompetitively, while others have engaged in anticompetitive conduct.

Multiprovider Network Joint Ventures. Historically, physicians were predominantly solo practitioners, but many physicians implemented network joint ventures in response to managed care. The 1980s saw the emergence of two types of joint ventures with physician members (Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs)). In general, IPAs are networks of independent physicians that, among other things, may contract with MCOs and employers. PHOs are joint ventures between a hospital (or more than one hospital) and physicians who generally have

admitting privileges there; hospital and physician members sometimes contract jointly through the PHO with MCOs to provide care to a population of patients.

IPAs and PHOs are often integrated to varying degrees financially (sharing financial risk) or clinically (using various strategies to improve the quality of care they provide) or both. Such joint ventures may provide various cost savings, such as reduced contracting costs, and clinical efficiencies, such as better monitoring and management of patients with chronic illnesses. IPAs and PHOs can also represent attempts by providers to increase their bargaining leverage with insurers. Some contend that the primary advantage for physicians and hospitals in forming a PHO is that the member hospital(s) and physicians present a united front for bargaining with payors. In recent years, the use of IPAs and PHOs has decreased, as MCOs and providers have abandoned capitation arrangements.

One antitrust issue that physician joint ventures confront with respect to their contracting practices is how to avoid summary condemnation under the antitrust laws. The *Health Care Statements* outline the key factors the Agencies will consider in determining whether to apply the per se rule or more elaborate rule of reason analysis to particular conduct.³ These factors include the degree of integration that the venture achieves to obtain efficiencies and the extent to which joint pricing is reasonably

³ DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), available at <http://www.ftc.gov/reports/hlth3s.pdf>.

necessary to achieve those efficiencies.

The “Messenger Model.”

Arrangements to allow networks of providers to contract with payors, while avoiding any agreement on price among the providers, sometimes use a “messenger” to facilitate contracting. The payor usually submits a proposed fee schedule to an agent or third party, who transmits this offer to the network physicians. Each physician decides unilaterally whether to accept the fee schedule, and the agent transmits those decisions to the payor. Providers may also individually give the messenger information about the prices or other contract terms that the provider will accept, and the messenger aggregates this information and markets it to payors. *Health Care Statement 9* describes how to avoid antitrust problems when using a messenger model, and provider networks have used the model successfully. Nonetheless, physician networks using so-called “messengers” to orchestrate or participate in price-fixing agreements have resulted in considerable antitrust enforcement activity in recent years.

Physician Collective Bargaining.

Some physicians have lobbied heavily for an antitrust exemption to allow independent physicians to bargain collectively. They argue that payors have market power, and that collective bargaining will enable physicians to exercise countervailing market power. The Agencies have consistently opposed these exemptions, because they are likely to harm consumers by increasing costs without improving quality of care. The Congressional Budget Office estimated that proposed federal legislation to exempt physicians from antitrust scrutiny would increase expenditures on private health

insurance by 2.6 percent and increase direct federal spending on health care programs such as Medicaid by \$11.3 billion.

Licensing Regulation and Market Entry. State licensing boards composed primarily of physicians determine, apply, and enforce the requirements for physicians to practice within a particular state. Various state licensing boards have taken steps to restrict allied health professionals and telemedicine. Some states have limited or no reciprocity for licensing physicians and allied health professionals already licensed by another state. The Report discusses the anticompetitive potential of such restrictions, as well as their rationales.

B. Hospitals

As with physicians, some hospitals have responded to competitive pressures by finding ways to lower costs, improve quality, and compete more efficiently. Some commentators contend, however, that a number of hospital networks are exercising market power to demand price increases from payors, and seeking to forestall entry by new competitors, such as single-specialty hospitals.

Hospital Networks. Over the past 20 years, many hospitals have merged or consolidated into multi-hospital networks or systems. Although the Agencies had considerable early success in challenging certain hospital mergers, the Agencies and state enforcers have lost all seven hospital merger cases they have litigated since 1994. Courts in these cases typically disagreed with the Agencies on how to measure relevant antitrust markets, how to assess the prospects for entry to remedy any

anticompetitive effects, how to determine the magnitude of any likely efficiencies, and the relevance of the hospital's nonprofit status. The Commission has undertaken a retrospective study to evaluate the market results in several consummated mergers, and one case is currently pending in administrative litigation.

Initially, national systems acquired hospitals throughout the United States, but recent acquisitions have been more localized. Some believe that hospital consolidation generally has promoted the development of efficiencies and instilled life back into failing hospitals. They point to the savings from consolidated operations that hospital networks may make possible. Others believe that a primary result of consolidation has been to create hospital market power, thus allowing hospitals to increase their prices. Hospitals claim that rising prices result not from market power, but from a multitude of pressures they confront, such as shortages of nurses and other personnel, rising liability premiums, the costs of improved technology, and the obligations of indigent care.

Most studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit. Some studies have found that merged hospitals experienced smaller price and cost increases than those that have not merged, except in highly concentrated markets, where the pattern was reversed. Another study found that some systems' acquisition of hospitals did not produce efficiencies, because of a failure to combine operations. Some have pointed out

that studies typically do not differentiate among transactions that occur within local markets and those that occur across markets, such as national system acquisitions; different types of consolidations might reflect very different hospital strategies and could have different efficiency effects.

Entry: Specialty Hospitals.

Specialty hospitals provide care for a specific specialty (*e.g.*, cardiac) or type of patient (*e.g.*, children). Newer single-specialty hospitals (SSHs) tend to specialize in cardiac or orthopedic surgery, and participating physicians often have an ownership interest in the facility, for reasons described *infra*. Some contend that SSHs have achieved better outcomes through increased volume, better disease management, and better clinical standards.

Others disagree, suggesting that physician-investors send healthier, lower risk patients to their SSH and sicker patients to a general hospital to enable the SSH to produce service less expensively yet still be reimbursed at the same rates as the general hospital. These commentators fear that SSHs will siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize socially valuable, but less profitable care.

Some general hospitals facing competition from SSHs have removed the admitting privileges of physicians involved with the SSH or otherwise acted to limit physician access to the general hospital; other general hospitals have established their own single-specialty wing to prevent physicians from shifting their patients to a new entrant. Some commentators state that general hospitals have used certificate of

need (CON) laws to restrict entry by SSHs. There are relatively few SSHs, and the vast majority are in states without CON programs. Debate about SSHs continues. A recently imposed Congressional moratorium on physician referrals to SSHs in which they have an ownership interest and two Congressionally mandated studies on SSHs and general hospitals will likely affect the future of SSHs.

Entry: Ambulatory Surgery Centers. Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Technological advances in surgery and anesthetic agents have made it possible for ASCs to perform a wide range of surgical procedures. Medicare reimbursement has had a profound effect on the number of ASCs and the amount and types of surgery performed in them.

Commentators express divergent views on ASCs, with some focusing on likely benefits to consumers including greater convenience, and others expressing concerns about ASCs similar to those regarding SSHs. Hospital reactions to deter ASC entry and restrict competition have been similar to those for SSHs.

Government Purchasing of Hospital Services. Government-administered pricing by CMS inadvertently can distort market competition. For example, CMS never decided as a matter of policy to provide greater profits for cardiac surgery than many other types of service, but the IPSS tends to do so. This pricing distortion creates a direct economic incentive for specialized cardiac hospitals to enter the market; such entry reflects areas that government pricing

makes most profitable, which may or may not reflect consumers' needs and preferences. When the government is the sole or primary payor for a service, such as kidney dialysis or vaccines, paying too much wastes resources, while paying too little reduces output and capacity, lowers quality, and diminishes incentives for innovation.

Although CMS can set prices, its ability directly to encourage price and non-price competition is limited. With few exceptions, CMS cannot force providers to compete for CMS's business or reward suppliers that reduce costs or enhance quality with substantially increased volume or higher payments. CMS has limited ability to contract selectively with providers or use competitive bidding. Even straightforward purchasing initiatives, such as competitive bidding for durable medical equipment (DME), have generated considerable resistance, despite the success of a pilot project for DME competitive bidding that resulted in savings of 17 to 22 percent with no significant adverse effects on beneficiaries. Worse still, CMS's payment systems do not reward providers who deliver higher quality care or punish providers who deliver lower quality care. As the Medicare Payment Advisory Commission reported, the Medicare payment system is "largely neutral or negative towards quality At times providers are paid even more when quality is worse, such as when complications occur as the result of error."⁴

⁴ MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (2003), available at http://www.medpac.gov/publications/congressional_reports/June03_Entire_Report.pdf.

CMS has worked to enhance quality through public reporting initiatives. For example, since CMS began public reporting of quality information on dialysis care in 1996, the number of patients receiving inadequate dialysis or experiencing anemia has declined substantially. Since 2002, CMS publicly reports on the quality of care provided in nursing homes and by home health agencies. Recently, CMS joined with hospitals and the Quality Improvement Organizations in Maryland, New York, and Arizona to design pilot tests for publicly reporting hospital performance measures. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 creates modest financial incentives for hospitals to report such information.

Examples of other government initiatives include New York State, which began to publicize provider-specific outcomes for cardiac surgery in 1989. By 1992, one study found risk-adjusted mortality had dropped 41 percent statewide, giving New York the lowest risk-adjusted mortality rate for cardiac surgery in the nation. Studies show the mortality rate has continued to fall. Pennsylvania reportedly experienced similar improvements when it began collecting and publishing risk-adjusted report cards.

Some have criticized these findings on methodological and policy grounds. For example, critics suggest that some of the improvement in mortality rates in New York resulted from the migration of high-risk patients to other states for surgery, and that data collection and risk adjustment methods were flawed. A general criticism of such “report cards” is that they discourage providers from treating higher risk patients.

More research is required to determine the best methods for measuring and reporting on hospital quality.

Private Purchasing of Hospital Services. In recent years, contracting between hospitals and private payors has sometimes been controversial and contentious. Some contend that many hospital systems include at least one “must-have” hospital in each of the geographic markets in which they compete. A “must-have” hospital is one that health care plans believe they must offer to their beneficiaries to attract employers to the plan. Payors complain that hospital systems insist on including all or none of the hospitals in a system in the payor’s coverage plan. Consumer pressure for open networks has made it more difficult for payors to exclude an entire hospital system, and the presence of a “must-have” hospital in the network also increases a hospital’s bargaining power. Although some commentators believe that particular hospitals and hospital systems have the upper hand in bargaining in some markets, bargaining advantage varies substantially within and among different markets.

In a few markets, certain payors have experimented with “tiering” hospitals, which results in different consumer co-payments depending on the hospital. Hospital tiers may be established based on a variety of criteria. Tiering usually does not apply to emergency care and may depend on where routine and specialty services are offered. Tiering allows a payor to maintain a broad network and include a “must-have” hospital, yet still create incentives for consumers to use lower cost hospitals. Hospitals usually resist tiering, in some cases negotiating

contracts that prohibit tiering. Hospitals express concern that low-cost facilities will be mislabeled as low quality and high-cost facilities as inefficient, and that tiering might force poorer consumers to use only low-cost hospitals.

Private-sector efforts are underway to provide more information about quality. A number of private initiatives seek to make quality-related information available to employers, health plans, and consumers. The Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance to assess health plans, uses more than 50 measures of provider and plan performance in areas such as patient satisfaction, childhood immunization, and mammography screening rates.

Hospital Purchasing. Some hospitals have joined group purchasing organizations (GPOs) to consolidate their purchases and achieve volume and other discounts. GPOs have the potential to assist hospitals in lowering costs. There have been complaints about certain GPO practices. The Agencies investigate GPO practices that appear to merit antitrust scrutiny. The market-share safety zones contained in *Health Care Statement 7* do not constrain Agency enforcement in cases involving anticompetitive contracting practices.

Consumer Price and Quality Sensitivity: The Need for Better Information. Tiering represents an attempt to force consumers to bear some of the increased price associated with receiving care at a more expensive hospital. Medical savings accounts, which combine a high-deductible insurance policy with a tax

advantaged fund for paying a portion of uncovered costs, are intended to accomplish the same goal for most health care purchasing decisions. For such strategies to work, however, consumers will need reliable and understandable information about the prices and quality of the services among which they must choose.

At present, most insured consumers are “rationally ignorant” of the price of medical services they receive, because insurance largely insulates them from the financial implications of their treatment. Even if consumers were interested in the price of their care, they would find it very difficult to obtain the information. The pricing of health care services is complicated and frequently obscure. Thus, proposals to increase consumer price sensitivity must develop strategies to increase the transparency of pricing.

An analogous finding emerges for quality measures. Although consumers typically express interest in report cards, they often do not use such information to select health plans and providers. If the information is usable, consumers will select treatments that accord with their preferences. Publicly available report cards can motivate providers to address quality deficiencies, even when it does not appear that many consumers rely on that information. Not all consumers must be well-informed for the market to deliver an efficient level of quality.

Pricing: Bulk Purchasing, Price Discrimination, Cost-Shifting, and Cross-Subsidies. Understanding health care pricing requires an understanding of four terms: bulk purchasing, price

discrimination, cost shifting, and cross subsidies. The terms have distinct meanings, although there is some overlap between cost shifting and cross subsidies. Bulk purchasing occurs when large organizations receive purchasing discounts because of the volume of their purchases. Price discrimination involves charging different consumers different prices for the same services, based on differential demand. Cost shifting refers to raising the price charged to one group of consumers as a result of lowering the price to other consumers. Cross subsidizing is the practice of charging profit maximizing prices above marginal costs to some payors or for some services and using the surpluses to subsidize other payors or other clinical services.

Some panelists stated that cost-shifting is common in the medical marketplace, but most commentators and panelists disagreed, and stated that bulk purchasing discounts and price discrimination explain observable pricing patterns. Panelists and commentators agreed, however, that there are a range of subsidies and cross-subsidies in the medical marketplace. For example, providers lose money by treating the uninsured, but make money by treating the well insured. Any administered pricing system has difficulty replicating competitive prices. Thus, not surprisingly, under Medicare's administered pricing system, some services are much more profitable than others.

Congress has also created direct subsidies for certain hospitals. CMS pays more to teaching hospitals (approximately \$5.9 billion in 1999) and to hospitals that provide a disproportionate share of care to the poor (approximately \$5 billion per year).

The existence of subsidies and cross-subsidies complicates any plan to give consumers better price information and increase their price sensitivity. Cross-subsidies can distort relative prices and makes access to care contingent on matters such as the number of uninsured that seek care, the wealth of the community, and the degree of competitiveness of the market for medical services.

C. *Pharmaceuticals*

Competition between Brand-Name and Generic Drug Manufacturers. The availability of patent protection creates innovation incentives for brand-name pharmaceutical companies by excluding others from making, using, or selling a claimed invention for a specified period of time. This protection helps ensure revenues to pharmaceutical firms that they can use for more research. Patent law also requires the disclosure of information about the patented invention that otherwise would remain a trade secret and thus encourages competition to design around brand-name patents.

In 1984, Congress passed the Hatch-Waxman Act, which has encouraged competition from lower-priced generic drugs. Hatch-Waxman has shaped substantially the legal environment governing Food and Drug Administration approval of generic drug products, and established a framework to balance incentives for continued innovation by brand-name firms with entry by generic drug firms.

The Commission has pursued several enforcement actions to remedy actions by particular firms to game certain Hatch-

Waxman provisions and deny consumers the benefits of generic competition that Congress intended. The Commission also issued a study in July, 2002 that addresses strategies among drug companies to affect the timing of generic drug entry prior to patent expiration. Congress has adopted the two major recommendations proposed in this study to preclude certain abuses of Hatch-Waxman.

Current Policy Debates. Concern about pharmaceutical prices in the United States has received much attention, and discussion continues about how best to address this issue. Certain policy choices currently under debate might lead to problems similar to those that this Report identifies in other health care sectors. For example, price regulation to lower prescription drug prices could lead to problems with administered pricing similar to those described above. Government purchasing that reflects monopsony power would likely reduce output and innovation.

PBMs. The use of pharmacy benefit managers (PBMs) as intermediaries between pharmaceutical managers and payors has raised questions whether PBMs increase the costs of pharmacy benefits. Pursuant to Congressional direction, the Commission is examining one aspect of these concerns: whether costs are higher if a payor uses a mail-order pharmacy integrated with a PBM rather than retail pharmacies or non-integrated mail-order pharmacies. This study is due in June, 2005. To date, empirical evidence suggests that PBMs have saved costs for payors.

Direct-to-Consumer Advertising. Some suggest that direct-to-consumer

advertising has increased prices for consumers or caused them to consume inappropriate prescription drugs. The available evidence does not support these allegations. Indeed, competition can help address these information problems by giving market participants an incentive to deliver truthful and accurate information to consumers. Nobel Laureate George Stigler once observed that advertising is “an immensely powerful instrument for the elimination of ignorance.”⁵ Studies by the FTC’s Bureau of Economics have confirmed that advertising provides a powerful tool to communicate information about health and wellness to consumers – and the information can change people’s behavior. Thus, good information is a necessary building block both for consumer empowerment and enhanced health.

V. RECOMMENDATIONS TO IMPROVE COMPETITION IN HEALTH CARE MARKETS

Competition has affected health care markets substantially over the past three decades. New forms of organization have developed in response to pressures for lower costs, and new strategies for lowering costs and enhancing quality have emerged. Nonetheless, competition remains less effective than possible in most health care markets, because the prerequisites for fully competitive markets are not fully satisfied. This list of recommendations focuses on how to encourage the development of prerequisites to competition such as good information about price and quality. The Agencies recognize that the work remaining

⁵ George J. Stigler, *The Economics of Information*, 69 J. POL. ECON. 213, 220 (1961).

to be done is complex and difficult and will take time. A renewed focus on the prerequisites for effective competition, however, may assist policymakers in identifying and prioritizing tasks for the near future.

Recommendation 1:

Private payors, governments, and providers should continue experiments to improve incentives for providers to lower costs and enhance quality and for consumers to seek lower prices and better quality.

a) Private payors, governments, and providers should improve measures of price and quality.

As noted above, health care pricing can be obscure and complex. Increased transparency in pricing is needed to implement strategies that encourage providers to lower costs and consumers to evaluate prices. Achievement of this goal will likely require addressing the issue of cross-subsidization, which encourages providers to use pricing that does not reveal the degree to which the well-insured may be subsidizing the indigent, and more profitable services may be subsidizing less well-compensated care.

A great deal of work already has been done on measuring quality. Quality measures exist for a considerable number of conditions and treatments. The Agencies encourage further work in this area. The Agencies suggest that particular attention be paid to the criticism that report cards and other performance measures discourage

providers from treating sicker patients. If it is not addressed, this criticism could undermine the perceived validity and reliability of information about quality.

b) Private payors, governments, and providers should furnish more information on prices and quality to consumers in ways that they find useful and relevant, and continue to experiment with financing structures that will give consumers greater incentives to use such information.

Information must be reliable and understandable if consumers are to use it in selecting health plans and providers. Research to date indicates that many consumers have not used the price and quality information they have received to make decisions about health plans and providers. Additional research into the types of price and quality information that consumers would use for those decisions appears to be necessary. Further experiments with varying co-payments and deductibles based on price- and quality-related factors such as the “tier” of service that consumers choose can help give consumers greater responsibility for their choices. Such responsibility will also likely increase consumer incentives to use available information on price and quality.

c) Private payors, governments, and providers should experiment further with payment methods for aligning providers’ incentives with consumers’ interests in lower prices, quality improvements, and innovation.

Payment methods that give incentives for providers to lower costs, improve quality, and innovate could be powerful forces for improving competition in health care markets. Although payors have experimented with some payment methods that provide incentives to lower costs, no payment method has yet emerged that more fully aligns providers' incentives with the interests of consumers in lower prices, quality improvements, and innovation. At present, for example, most payments to providers have no connection with the quality of care provided.

A focus on the degree to which providers' incentives are compatible with consumers' interests is important. Compatible incentives and interests are more likely to yield better results; incompatible incentives and interests are more likely to have unintended consequences that can lead to worse results. Initiatives that address the use of payment methods to align providers' incentives with consumers' interests are necessary. These experiments should be carefully analyzed to evaluate their consequences, both intended and unintended.

Recommendation 2:

States should decrease barriers to entry into provider markets.

a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.

The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they

pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single-specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.

b) States should consider adopting the recommendation of the Institute of Medicine to broaden the membership of state licensure boards.

State licensing boards are disproportionately composed of licensed providers, although some states require broader representation. Many state licensing boards have taken steps, such as restricting allied health professionals (AHPs) from independent practice and direct access to consumers, that significantly reduce certain forms of competition. State licensure boards with broader membership, including representatives of the general public, and individuals with expertise in health administration, economics, consumer affairs, education, and health services research, could be less likely to limit competition by AHPs and new business forms for the delivery of health care, and are less likely to engage in conduct that unreasonably increases prices or lowers access to health care.

c) States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.

When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality. When used improperly, telemedicine has the potential to lower health care quality and to increase the incidence of consumer fraud. To foster telemedicine's likely pro-competitive benefits and to deter its potential to harm consumers, states should consider implementing uniform licensure standards or reciprocity compacts. Uniform licensure standards and reciprocity compacts could operate both to protect consumers and to reduce barriers to telemedicine. State regulators and legislators should explicitly consider the pro-competitive benefits of telemedicine before restricting it. Similar considerations apply to the potential for licensure to restrict competition from out-of-state providers who wish to move in-state.

Recommendation 3:

Governments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition.

Health care markets have numerous cross-subsidies and indirect subsidies. Competitive markets compete away the higher prices and supra-competitive profits necessary to sustain such subsidies. Such competition holds both the promise of consumer benefits and the threat of

undermining an implicit policy of subsidizing certain consumers and types of care.

Competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent. Governments should consider whether current subsidies best serve their citizens' health care needs.

Recommendation 4:

Governments should not enact legislation to permit independent physicians to bargain collectively.

Physician collective bargaining will harm consumers financially and is unlikely to result in quality improvements. There are numerous ways in which independent physicians can work together to improve quality without violating the antitrust laws.

Recommendation 5:

States should consider the potential costs and benefits of regulating pharmacy benefit manager transparency.

In general, vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms. Just as competitive forces encourage PBMs to offer

their best price and service combination to health plan sponsors to gain access to subscribers, competition should also encourage disclosure of the information health plan sponsors require to decide with which PBM to contract. To the extent the Commission’s Congressionally mandated study of PBMs provides relevant information to the issue of PBM transparency, it will be discussed in the Commission’s study report.

Recommendation 6:

Governments should reconsider whether current mandates best serve their citizens’ health care needs. When deciding whether to mandate particular benefits, governments should consider that such mandates are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans.

State and federal governments mandate numerous health insurance benefits. Proponents argue that mandates can correct insurance market failures, and that the required inclusion of some benefits in all health insurance plans can be welfare enhancing. Opponents argue that the case for many mandates is anecdotal, and that mandates raise premium costs, leading employers to opt out of providing health insurance and insured individuals to drop their coverage. Opponents also note that providers of the mandated benefit are usually the most vigorous proponents of such legislation, making it more likely that the mandated benefits may constitute

“provider protection” and not “consumer protection.” The Commission has submitted numerous competition advocacy letters on this issue in the last fifteen years, focusing on any willing provider and freedom of choice provisions.

For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay the marginal costs. This task is challenging under the best of circumstances – and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans.

State and federal policy makers should consider ways of evaluating these risks in their decision making processes and reconsider whether current mandates best serve their citizens’ health care needs.

VI. AGENCY PERSPECTIVES ON ISSUES IN ANTITRUST ENFORCEMENT IN HEALTH CARE

The Agencies have been active for nearly 30 years in health care markets, challenging anticompetitive conduct and providing guidance to consumers and industry participants. This section outlines the Agencies’ perspective on several issues in antitrust enforcement in health care markets.

A. Perspective on Physician-Related Issues

Physician Joint Ventures and Multi-provider Networks. *Health Care Statement 8* provides that “physician network joint ventures . . . will not be viewed as per se illegal, if the physicians’ integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to achieve those efficiencies.” *Health Care Statement 8* further notes that financial risk-sharing and clinical integration may involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies.

1st Observation:

Payment for performance arrangements among a group of physicians may constitute a form of financial risk-sharing.

In determining whether a physician network joint venture is sufficiently financially integrated to avoid *per se* condemnation, the Agencies will consider the extent to which a particular payment for performance (P4P) arrangement constitutes the sharing of substantial financial risk among a group of physicians, and the relationship between the physicians’ pricing agreement and the P4P program.

2nd Observation:

The Agencies do not suggest particular structures with which to

achieve clinical integration that justifies a rule of reason analysis of joint pricing, but the analysis of whether a physician network joint venture is clinically integrated may be aided in some circumstances by asking questions like those outlined in Chapter 2.

Attempts to achieve clinical integration were discussed at length at the Hearings. Panelists described a wide variety of factors as possibly relevant to evaluating clinical integration. Panelists and commentators asked the Agencies to define the criteria that the Agencies will consider sufficient to demonstrate that a particular venture is clinically integrated. The Agencies do not suggest particular structures with which to achieve clinical integration that justifies a rule of reason analysis of joint pricing, because of the risk that it would channel market behavior, instead of encouraging market participants to develop structures responsive to their particular goals and the market conditions they face. As an aid to analysis, Chapter 2 of the Report includes a broad outline of some of the kinds of questions that the Agencies are likely to ask when analyzing whether a physician network joint venture is clinically integrated.

B. Perspective on Hospital-Related Issues

Hospital Mergers. The Agencies will continue carefully to evaluate proposed hospital mergers and to challenge those with likely anticompetitive effects. Certain issues addressed in hospital merger cases are discussed below.

3rd Observation:

Research on hospital product markets is encouraged.

In most cases, the Agencies have analyzed hospital product markets as a broad group of acute, inpatient medical conditions where the patient must remain in a health care facility for at least 24 hours for treatment, recovery or observation. The Agencies continue to examine whether smaller markets exist within the traditional cluster product market definition or other product market adjustments might be warranted, and encourage research on these matters. For example:

- The percentage of total health care spending devoted to outpatient care is growing. The Agencies encourage research on whether services provided in outpatient settings may constitute additional relevant product markets, and if so, whether those services might be adversely affected by a hospital merger.
- In recent years, single-specialty hospitals have emerged in numerous locations. The Agencies encourage further research into the competitive significance of SSHs, including whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs.
- The Agencies encourage additional research to validate or refute the analytical techniques for defining product markets suggested by various commentators and panelists.

4th Observation:

Hospital geographic markets should be defined properly.

The definition of hospital geographic markets has proven controversial. In connection with this Report, the Agencies undertook a substantial analysis of how best to determine the contours of the relevant geographic market in which hospitals operate, consistent with the process described in the *1992 Horizontal Merger Guidelines (Merger Guidelines)*. The Agencies' conclusions are:

- a) The "hypothetical monopolist" test of the *Merger Guidelines* should be used to define geographic markets in hospital merger cases. To date, the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases. The limitations and difficulties of conducting a proper critical loss analysis should be fully considered if this method is used to define a hospital geographic market.
- b) The types of evidence used in *all* merger cases – such as strategic planning documents of the merging parties and customer testimony and documents – should be used by Courts to help delineate relevant geographic markets in hospital merger cases. Evidence regarding the willingness of consumers to travel and physicians to steer consumers to less expensive alternatives should also be considered by Courts.

- c) The Agencies encourage additional research to validate or refute the analytical techniques for defining geographic markets suggested by various commentators and Hearings participants.

5th Observation:

Hospital merger analysis should not be affected by institutional status.

The best available evidence shows that the pricing behavior of nonprofits when they achieve market power does not systematically differ from that of for-profits. The nonprofit status of a hospital should not be considered in determining whether a proposed hospital merger violates the antitrust laws.

6th Observation:

The resolution of hospital merger challenges through community commitments should be generally disfavored.

The Agencies do not accept community commitments as a resolution to likely anticompetitive effects from a hospital (or any other) merger. The Agencies believe community commitments are an ineffective, short-term regulatory approach to what is ultimately a problem of competition. Nevertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face.

C. General Issues

7th Observation:

The safety zone provision of *Health Care Statement 7* does not protect anticompetitive contracting practices of group purchasing organizations.

Health Care Statement 7 and its safety zone aim to address monopsony and oligopoly concerns with the formation of a GPO. This statement does not address all potential issues that GPOs may raise. The Agencies believe amending the statement to address some, but not all potential issues, is likely to be counterproductive. *Health Care Statement 7* does not preclude Agency action challenging anticompetitive contracting practices that may occur in connection with GPOs. The Agencies will examine, on a case-by-case basis, the facts of any alleged anticompetitive contracting practice to determine whether it violates the antitrust laws.

8th Observation:

Countervailing power should not be considered an effective response to disparities in bargaining power between payors and providers.

Although there appear to be disparities in bargaining power between some payors and some providers, the available evidence does not indicate that there is a monopsony power problem in most health care markets. Even if it were assumed that providers confront monopsony health plans, the Agencies do not believe that allowing providers to exercise

countervailing power is likely to serve consumers' interests.

9th Observation:

Private parties should not engage in anticompetitive conduct in responding to marketplace developments.

The permissibility of unilateral and collective provider conduct in response to marketplace developments (including P4P, tiering, SSHs, and ASCs) is raised in several different settings in the Report. Generally speaking, antitrust law permits unilateral responses to competition. If there is specific evidence of anticompetitive conduct by individual providers or provider collusion in response to marketplace developments, the Agencies will aggressively pursue those activities.

10th Observation:

The state action and Noerr-Pennington doctrines should be interpreted in light of the principles that justified those doctrines in the first place.

The state action and Noerr Pennington doctrines curb competition law to promote important values such as federalism and the right to petition the government for redress. Inappropriately broad interpretations of these doctrines can chill or limit competition in health care markets. It is important to recognize both the genuine interests these doctrines serve as well as the anticompetitive consequences that result from an overly expansive interpretation of their scope.

11th Observation:

Remedies must resolve the anticompetitive harm, restore competition, and prevent future anticompetitive conduct.

Remedies are a critical issue in implementing an effective competition policy. Optimal enforcement must steer between over-deterrence and under-deterrence. Over-deterrence may occur if conduct that is not, in fact, anticompetitive is challenged, or if excessive sanctions are imposed on anticompetitive conduct. Under-deterrence may occur if anticompetitive conduct is not identified and addressed, or if inadequate remedies are imposed in response to such conduct. The Agencies must avoid both of these extremes to effect optimal deterrence, while recognizing that bringing cases helps create a "compliance norm."

The Agencies view all anticompetitive conduct as serious, and will seek appropriate sanctions. In general, much more stringent measures are necessary against those who violate the antitrust laws repeatedly or flagrantly and those who facilitate anticompetitive conduct by multiple parties. The Division will also pursue criminal sanctions in appropriate cases. Disgorgement and/or dissolution will be sought in appropriate cases.

VIII. CONCLUSION

The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services

such as health care are involved. The Agencies play an important role in safeguarding the free-market system from anticompetitive conduct, by bringing enforcement actions against parties who violate the antitrust and consumer protection laws. To be sure, in some instances compelling state interests may trump or limit free-market competition. The Agencies play an important role here as well, by making policy makers aware of the costs of impediments to competition, and by advocating for competitive market solutions.

The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace. What the Agencies do have is a commitment to vigorous competition on both price and non-price parameters, in health care and in the rest of the economy. Much remains to be accomplished to ensure that the market for health care goods and services operates to serve the interests of consumers. This Report identifies concrete steps to improve competition in the health care marketplace, and improve the application of competition law to health care.