



DEPARTMENT OF JUSTICE

"MARKET - BASED REFORM OF HEALTH CARE DELIVERY: WHERE DOES ANTITRUST FIT IN?"

Address by

STEVEN C. SUNSHINE
Deputy Assistant Attorney General
Antitrust Division
U.S. Department of Justice

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There is little doubt that we are experiencing dramatic changes in health care delivery. Approximately one hundred hospitals close or merge each year. At the same time, the growth of managed care is a nation-wide phenomenon, with penetration exceeding 90% of private-pay patients in some markets. New forms of multi-provider networks, combining providers of both competing and complementary services, are emerging in markets across the country. And continuous advances in technology change the nature of the services offered to and demanded by patients.

While it would be difficult to explain all of the forces behind this dynamic, it is nonetheless safe to say that at bottom, these changes are driven by market forces. As total health care expenditures approach one-sixth of the nation's gross national product, there are increasing cries for cost containment. Employers have looked for ways to lower the cost of insuring their employees. Payors have devised innovative new systems to spread risk and monitor utilization. Responding to competitive pressures, hospitals have sought to capture efficiencies and eliminate duplication. These efforts have resulted in decreased utilization, particularly in in-patient hospitalization, exacerbating the problem of excess capacity.

Changes in technology have fundamentally affected market demand. New procedures allow patients to be treated with higher quality and in a less intrusive fashion. Many of these improvements have increased use of out-patient procedures and obviated the need for hospital admissions. New equipment, often highly capital intensive, offers improved treatment or diagnosis. Not all providers, however, can afford to make investments in such equipment.

These market forces have spawned a wave of efforts to rationalize and eliminate

excess capacity. As antitrust enforcers, we are called on to review many of these efforts, including mergers among competitors, vertical mergers, partnerships and joint ventures, and a host of contractual arrangements, all designed to secure for the participants a place in the changing market.

What is the role of antitrust review in this dynamic market? Before turning to that question, let me start with my basic assumption -- competition works in the health care industry. It works best where there are knowledgeable purchasers that can base purchasing decisions on adequate information and where purchasers have financial incentives to select the services that offer the best combination of price and quality. But, of course, competition works only where purchasers have choices.

To date, managed care is the best instrument of competition and cost containment that we have observed. The success of managed care rests on its ability to assemble information, provide financial incentives, and to shift demand to preferred providers. Its effectiveness has been shown empirically by many. For example, in California where managed care has achieved high levels of penetration, the average bed days per thousand patients, hospital price levels, and hospital price increases are significantly lower than the national average.

The benefits of competition are not limited to those that are static. Competition is also the best way to insure innovation, and innovation, of course, serves to allow markets to evolve into more efficient delivery systems. Over the last year and a half, the Department has emphasized the importance of innovation, in fact, for the first time ever challenging a merger on the grounds that it would lessen competition in an innovation market. That case, *United States v. General Motors*, involved a heavy duty truck transmission market, but its

principles are just as apt in health care.

Innovation in health care has led to the formation of more efficient firms and arrangements. For example, many physicians are now assuming risk for their patients' utilization of services, incenting physicians to strive for cost containment and to limit unnecessary treatment. Managed care providers are innovating point-of-sale plans. Competitive conditions have spurred hospitals to work with their managed care customers to reduce utilization and provide better care. Additionally, hospitals are participating in networks and are teaming with other providers and insurers to offer innovative new services.

To state my thesis simply, let me say that the role of antitrust in health care is to promote consumer welfare primarily through competition in free and open markets. Open markets promote price and quality competition, increased information, and, perhaps most importantly, innovation. As antitrust prosecutors, however, we do not view ourselves as regulators of these markets. Generally speaking, the market ought to be left to market forces -- with antitrust enforcement stepping in only when competition is threatened through either noncompetitive market structures or restraints imposed by private parties.

Antitrust, of course, is not blind to efficiencies. Efficiencies may be achieved through cooperation among parties in mergers and joint ventures and through contractual arrangements. We typically balance the procompetitive effects of the likely efficiency gains of a proposed arrangement against its likely harm to competition.

Antitrust polices markets in two principal ways. First, antitrust enforcement prevents noncompetitive market structures, typically through merger policy. Second, antitrust enforcement prevents and removes private restraints that can lead to excessive prices, entry barriers, foreclosure and denial of access, or other competition-limiting practices.

The vitality of antitrust enforcement in health care was reaffirmed by the Department of Justice and Federal Trade Commission's Statements of Enforcement Policy. The Statements were issued first in September of 1993, and then expanded in September of 1994. The statements describe antitrust enforcement policy and provide clear guidance to the health care community on how enforcement impacts nine major types of practices. With clear guidance, the health care community can plan and carry out innovative business arrangements without fear of antitrust challenge. For those types of practices that are close questions, the parties can seek an expedited business review letter from the Department and receive a statement of enforcement intentions within 90 days.

Our recognition of the importance of competition and antitrust does not mean that there are not other social policies that may possibly require other solutions. We recognize that there may be issues of risk selection, universality, uncompensated care, and cost shifting that cannot always be adequately solved through competition. But the existence of these issues does not diminish our belief that competition is the principle avenue for cost containment and innovation in the health care industry.

I will turn now to merger policy. As in any other industry, mergers present both the opportunity for efficiency gains as well as for the creation or the enhancement of market power. The Department uses the 1992 Horizontal Merger Guidelines to gauge a merger's likely competitive effects and efficiencies and to determine whether the transaction is likely to lead to higher prices, reduced output, or lessened innovation. The Merger Guidelines are flexible and general enough to subsume many specific health care issues. For example, the Department takes account of: (1) the effect of insurance on incentives; (2) the effect of regulatory constraints on price and availability of new services; (3) the role of the physician

and the physician-patient relationship; (4) the not-for-profit status of some market participants; and (5) the implications of an individual's lack of information.

While the Department often reviews many different types of health care mergers, its enforcement actions to date have been limited to hospital mergers. HMO's typically compete with other HMO's and often face some competition from other types of insurance plans. Physician groups typically face competition from many other physician groups. To date, proposed HMO and physician group mergers have not raised competitive concerns. This record, however, may change in the foreseeable future. Increasing HMO penetration and consolidation may lead to local markets where an HMO merger could create or enhance market power. As physician groups in many local markets grow, the point may be reached where additional mergers -- whether horizontal or vertical -- raise concerns.

In the past year, the Department challenged two hospital mergers. In *United States v. Morton Plant*, the Department challenged the merger of two hospitals with a combined share of 60% of the Clearwater, Florida market. Approximately two months after filing that case, the Division reached a settlement with the hospitals resolving the litigation. I will return to the settlement in a few minutes. The second hospital merger challenge was *United States v. Mercy Health Systems*. In that case, the Department sought to prevent the merger of the only two hospitals in the Dubuque, Iowa market. This case was tried in Cedar Rapids, Iowa in October and we are awaiting decision.

The Department's analysis of hospital mergers is in principle no different than its general merger analysis. We look to the likely anticompetitive effects and possible efficiency gains to determine whether the net effect of the transaction will be to harm consumers. In hospital merger analysis, the Department typically focuses on in-patient

services, usually concluding that the merger's effects on out-patient services will not be harmful, either because there are non-acute-care hospital providers of these services in the market, or entry into those services would be easy. In hospital mergers, two key issues are almost always geographic market definition and efficiencies. I won't dwell on geographic market analysis other than to mention that these markets are typically local.

I also would like to note that we often hear from merging parties that the transaction is needed to balance the hospital's power against the growing power of managed care. We typically don't credit arguments of countervailing power. We are skeptical that monopsony power wielded by managed care providers is likely to have serious welfare effects since demand for in-patient service may be quite inelastic. Without a clear view of a welfare loss, we would not be inclined to intervene when the alleged "harm" is lower prices.

I would like to turn now to efficiencies briefly. The Division puts great importance on analysis of efficiencies. In the last year, we have allowed several mergers to proceed on the basis of likely efficiency gains even though they exceeded our structural guidelines for presumptive anticompetitive effects.

In evaluating efficiencies we look to four general criteria. First, we focus on the claimed efficiencies and evaluate their likely size. Next, we ask whether the efficiencies will be realized, especially in light of the desires of the relevant medical staffs and the local community. Third, we ask whether the efficiencies are merger specific. For instance, claims of efficiencies through improved "best practices" are viewed with great skepticism since best practices can be and usually are achieved without merger. Last, we ask if the benefits from the merger are likely to be passed on to consumers directly or indirectly through lower prices and costs.

As a general matter, merger efficiency analysis is complicated by the fact that the parties are not starting from a blank slate; each has significant sunk costs. For instance, analyzing the efficiency gains if two 200-bed hospitals come under common ownership may be a far different question than determining the efficiency of one 400-bed hospital compared to two 200-bed hospitals.

Typically few efficiencies arise from the mere unification of economic ownership. If a hospital merger results in a consolidation of campuses, we are most likely to credit maximum efficiencies in this circumstance. However, we rarely see hospital merger partners proposing consolidation of campuses. This may be due to a number of factors: (1) two existing hospitals represent a substantial amount of sunk costs and it may be less costly to keep both hospitals open than to shut one down and expand capacity at the other; (2) the medical staffs at the two hospitals may make consolidation difficult; and (3) the community objects to the loss of the convenience of two campuses.

Merging hospitals typically propose consolidation of clinical services as part of their strategic planning. This consolidation may provide both operating and capital savings. However, the savings may not be substantial if both hospitals fully utilize their minimum staffing requirements, such that additional staffing is at variable cost.

The most extreme situation concerning efficiencies arises in the instance when the parties seek to justify a merger to monopoly on the grounds of efficiencies. Of course, the analysis must weigh the anticompetitive effects of the monopoly against the expected efficiencies. But we start with the presumption that the anticompetitive effects of monopoly are severe. Certainly natural monopoly means a loss of price competition and, in fact, regulation is often imposed to avoid the tendency of natural monopolies to price significantly

above marginal cost. This is most likely not a workable solution in the hospital context, and certainly not one the Department would initiate.

Monopoly may also lessen innovation, either by the monopolist itself, or by the monopolist's unwillingness to accommodate the innovative efforts of others. In today's dynamic health care market, the possible efficiency losses are large.

We also question whether proposed efficiencies will be achieved in the absence of competition over the long run. While most would predict that monopolists have significant incentives to lower costs, a hospital's incentives, especially nonprofits, may get distorted by other interests. The interests of the medical staff or community may override the hospitals' interest in certain cost-saving measures. Additionally, many nonprofit hospitals are part of larger nonprofit causes and revenue from hospital services may be used to cross-subsidize other causes.

For all these reasons, we remain skeptical of approving natural monopoly on the basis of efficiency gains.

One transaction where we were able to promote efficiencies gains was our settlement of *United States v. Morton Plant*. As I mentioned previously, that suit challenged the proposed merger of the two largest hospitals in Clearwater, Florida. I should also note that that challenge was joined by the Florida State Attorney General.

Two months into the litigation, we met with the merging hospitals and explored ways to accomplish most of the parties' proposed efficiencies without a full-scale merger. After days of intensive negotiation, we found an innovative solution that made business sense to the parties and promoted rather than lessened competition.

The settlement had two parts. First, the merger was prohibited and the two hospitals

agreed to remain independent providers of in-patient acute care services. Both hospitals agreed to continue to contract separately with managed care. Second, the hospitals could capture efficiencies through a production joint venture. The services that could be performed by the joint venture fell into three categories: certain tertiary services; out-patient care; and ancillary services.

Competition for the services contributed to the joint venture was protected in two important ways. First, we determined that the services in the joint venture would face competition from many other firms either because the markets were broader geographically than the general in-patient services market or firms other than the acute-care hospitals were participants or likely entrants. Tertiary services likely compete in a geographic market broader than the Clearwater, Florida market. If the market for these tertiary services extended just to the Tampa Bay area, 39 other hospitals provide comparable services. With respect to out-patient care, the Department found that out-patient services were provided by urgent care facilities, doctors' offices, and clinics. Last, the ancillary services such as laundry, billing, management information services and purchasing were all provided in a much larger market than just the Clearwater, Florida area.

The second protection is that the venture is limited to production only. While the venture can jointly produce the services, it must sell them back to each parent hospital at cost. Each hospital will separately market those services to managed care plans and others, often in competition with each other.

The joint venture has been in operation now for about four months. The hospitals have reported back to us that the joint venture is likely to achieve \$8 million of savings in its first year. Interestingly, the hospital administrators told us that the consolidation of

clinical services is far more difficult than they first imagined. They have scaled back their plans but are still planning some future clinical consolidations.

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In conclusion, I would like to reiterate that antitrust enforcement has an important role to play in the market-driven reform of the health care industry. Free and open markets usually lead to innovative and efficient solutions. It is the job of antitrust enforcement, to the maximum extent possible, to keep those markets free and open.