Department of Justice

"HEALTH CARE COST CONTAINMENT
AND COMPETITION"

REMARKS OF
JAMES F. RILL
ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

BEFORE
"A DAY WITH JUSTICE"
A SYMPOSIUM OF
THE NATIONAL LEGAL CENTER
FOR THE PUBLIC INTEREST

Washington, D.C.
April 23, 1991

It is a pleasure to be here today and to accept the suggestion of the program chairman to discuss the role of the Antitrust Division in health care cost containment efforts. This issue is appropriately of extreme concern to business given the rapid rise in health care costs. In 1960, businesses spent four to eight cents of each profit dollar on health care. Today that figure is 25 to 50 cents. Business leaders are searching for ways to provide their employees with quality health care in a cost-effective manner. The Antitrust Division, through its enforcement actions and competition advocacy program, supports the development and expansion of new health care delivery systems which have the potential to alleviate the problem of spiraling health care costs.

Historically, the health care industry has lacked incentives for providers and consumers to be cost conscious. Most patients' medical bills have been reimbursed by employer-provided health care insurance or government programs. Patients, therefore, had little incentive either to limit the number of services provided to them to those that are cost-effective, or to shop for providers that supply quality care at a reasonable price. By the same token, business and health insurers have lacked mechanisms to negotiate with providers to obtain the best combination of price and quality or to direct employees to cost-efficient providers.

Under this system, health care costs have dramatically increased and both government and business have begun searching for ways to cope. Their efforts have created new forms of delivery systems that use competitive forces to encourage more cost conscious behavior by providers and consumers. Managed care plans, such as Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs), allow businesses and other third-party payers to contract selectively with providers that will work with them to control costs. Providers must compete for the business of managed care systems by offering the best combination of price and quality, and payers can reward cost-efficient providers by directing more patients to them.

Numerous stories have appeared in the public newspapers and in trade journals recounting the experiences of businesses with managed care systems. The range of ideas presented in those articles attest to the creativity of the companies in designing and implementing managed care systems to meet the individual needs and preferences of their employees. It also demonstrates the diversity of benefit packages and plans that can be made available to consumers by managed care systems.

The Federal antitrust enforcement agencies have a responsibility to support emerging competition among health care providers through aggressive as well as principled antitrust enforcement. For competition to take hold, the market must be allowed to operate free of the illegal exercise of market

power. Competition is our best vehicle for curbing spiraling health care costs, and antitrust enforcement is the most efficient and least intrusive method of preserving the market for competition. Consequently, the Division's enthusiasm for new and innovative forms of managed care systems is matched only by our determination to send a clear message that antitrust violations will not go unchallenged.

The Divisions enforcement efforts in the health care area focus primarily on two areas: anticompetitive mergers and agreements in restraint of trade among competing providers. Let me take a moment to highlight our efforts in each of those areas.

Merger enforcement is one of the two top priorities of the Antitrust Division, and that priority extends to hospital mergers. In the past, we challenged several anticompetitive mergers between competing hospitals, and we will continue to be vigilant in this area. Let me emphasize, however, that before challenging a merger, the Division performs an extensive and exhaustive investigation. We recognize that not all mergers are anticompetitive; most are competitively neutral or even procompetitive. In particular, we do not wish to stop mergers with significant, demonstrable efficiencies and insubstantial or no anticompetitive harm. Following this approach, the Division and its sister agency, the Federal Trade Commission, have challenged only a very small percentage of the hospital mergers that are consummated each year in this country.

In cases where the Division has challenged mergers it is because our investigation has found that the merger would allow the merged entity, either unilaterally or through coordination with rival hospitals, to raise prices for hospital services. Of particular concern is the impact of these mergers on the efforts of third-party payers to develop and implement managed care systems to control health care costs.

In our case in Rockford, Illinois two years ago, the judge ruled that the merger of two of the three hospitals in that community would substantially lessen competition. He also found that the three Rockford hospitals, all of them not-for-profit, had previously colluded in negotiating new contracts with Blue Cross in an effort to obtain higher reimbursements. This demonstrates that the potential for anticompetitive conduct exists in health care markets as in any other industry.

I anticipate that there will be additional challenges to mergers of providers where our investigations disclose that the merger could increase the price consumers would have to pay for health care services.

Although it did not involve health care providers, our challenge to the Pepto-Bismol/Maalox marketing agreement demonstrates how our enforcement activities assist in the effort to control health care costs. Last year, the Division moved to challenge a proposed joint marketing agreement between Proctor & Gamble Company and The Rorer Corporation relating to the marketing of Pepto-Bismol and Maalox. This agreement would have combined the marketing resources and decisions of the

manufacturers of the nation's second and third best-selling over-the-counter stomach preparations. Our investigation indicated that the two companies' remedies acted as particularly close substitutes for one another and served as competitive restraints on each others' pricing. Our review indicated that the other existing suppliers in the market would be unable to respond to the lessening of competition associated with the agreement and that new entry was unlikely to offset the competitive effect. After the Department filed suit, the parties announced that they would seek a voluntary dismissal based on their decision to abandon the transaction.

At least equally important to our merger work, the Division will always investigate and will challenge, where appropriate, agreements between independent competing providers that restrain competition. Those agreements that are per se unlawful -- that is, restraints that are inherently likely to restrict output or raise price without the likelihood of any significant efficiency benefit -- are almost always subject to criminal prosecution. These agreements include price fixing, bid rigging and horizontal market allocations. Health care professionals receive no special treatment under the antitrust laws. If they engage in per se illegal conduct, they are very likely to find themselves the target of a criminal prosecution.

Recently, the Division tried its first price-fixing case against health care professionals in 50 years. In 1990, three dentists and two dental corporations were indicted on charges of

conspiring to fix and raise the copayment fees that members of various competing prepaid dental insurance plans were required to pay to the defendants and other dentists. The dentists were compensated by a capitation schedule -- in other words, they were paid a predetermined monthly amount for each subscriber who selected them as the provider. Services provided by the dentists that were not specifically covered by the capitation schedule were compensated by direct payments from the subscriber to the provider at rates independently determined by each plan. These copayments were the fees that the dentists wanted raised.

Led by the three individual defendants, more than 30 dentists sent identical letters to each of the plans for which they provided services. The form letter demanded an increase in copayment fees and attached a new copayment schedule that was 25-30 percent higher than the old one. The dentists banded together for the purpose of forcing a fee hike among the competing plans. All defendants were convicted by the jury, although the district court judge overturned those verdicts. This case is presently on appeal.

It is important to note that the Tucson dentists case has no bearing to the formation or operation of a legitimate PPO. This was not a situation in which a group of providers joined together to offer a new product or to take advantage of efficiency-enhancing economic integration. To the contrary, this collusion among providers to competing managed care plans sought to destroy the competitive benefits that makes the plans

so valuable to health care cost containment. This was per se illegal conduct and properly was prosecuted as a criminal violation.

The Division recognizes that the formation of PPOs generally is procompetitive, and examines the impact of legitimate provider-controlled PPOs under a rule of reason approach. Under this analysis, the agreement, the market in which the providers compete, and the industry would be evaluated to determine whether on balance it is an unreasonable restraint of trade. In analyzing the formation of PPOs, the Division uses an approach similar to our approach with joint ventures in other industries. As a general rule we would look skeptically at the formation of a PPO among a large percentage of providers in a particular specialty in a market area unless there is a clear procompetitive, efficiency-enhancing reason why this PPO needs to be so inclusive. Our concern is that overly-inclusive provider-controlled PPOs may interfere with the development and operation of managed care systems.

In the past the Division has stated that it would not be concerned with a PPO that has less than 35 percent of all providers in a community. However, we have gained greater experience with PPOs, and we have come to the realization that a richer analysis is needed. Like other types of joint ventures, PPOs are now initially examined as a merger under the Merger Guidelines. There are still numerical safeharbors, but their application requires information on the antitrust markets for

the providers' services and the existence of other competing PPOs. In situations where there are many PPOs competing in the market each with a small percentage of providers within a specialty, the formation of a new PPO is unlikely to raise competitive concerns. PPOs falling outside these safeharbors require further analysis under the Merger Guidelines -- analysis that is too extensive to discuss in these brief remarks. If our merger analysis suggests a merger between the PPO providers is likely to substantially lessen competition, we conduct a further inquiry to determine whether the actual formation or operation of the PPO would vitiate those competitive concerns.

In addition to our enforcement actions, the Division has also been extensively involved, as part of our competition advocacy program, in discussions with other Federal agencies related to the role of competition in health care cost containment efforts. We view this as a great opportunity to bring our expertise in competition theory and the formation of managed care systems to bear on this important problem.

In closing, I want to emphasize that enforcement activities in the health care field are an important priority in the Division. Antitrust enforcement and competition go hand in hand; by deterring anticompetitive abuses, we preserve a competitive market and increase the odds that managed care systems will develop and deliver to consumers quality care at reasonable prices.