DEPARTMENT OF JUSTICE

"RECENT ACTIVITIES OF THE ANTITRUST DIVISION IN THE HEALTH CARE FIELD"

Address by

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I. Introduction

I am pleased to be here today to discuss the Antitrust Division's recent activities in the health care industry and the role competition plays in ensuring that consumers receive affordable, yet high quality, health care services.

The health care industry is rapidly changing. In response to escalating health care costs, employers and other purchasers of health care services are increasingly turning from traditional, cost-based indemnity insurance to innovative, cost-conscious health care plans such as HMOs and PPOs. The salient characteristic of this new environment is the ability of managed care purchasers of health care services to direct their business to particular doctors, hospitals and other health care providers that have agreed to serve their enrollees on specified terms. Thus, providers must now compete for those purchasers' business on the basis of price, quality and efficiency. And, as long as those health care plans in turn sell their product in a competitive market, we can expect the savings and other benefits they derive from provider competition to be passed on to their enrollees. The emergence of these "price-sensitive" managed care purchasers makes it possible for competition to do for health care what it does in other sectors of the economy: promote lower prices, improved efficiency and other forms of consumer-benefiting innovation.

In this new competitive environment, some health care providers have been exploring mergers, joint ventures and other collaborative activities as a way to achieve greater efficiency and improved quality and position themselves as effective players in the market. Antitrust enforcement does not stand in the way of such activities. Indeed, to the extent they result in innovations that will offer managed care customers an expanded array of choices, we applaud them.

In some cases, however, providers seek to join forces with their competitors in order to protect - or even to increase - their bargaining power and reduce the impact of managed care. Some argue that this is an appropriate objective on the theory that such providers seek merely to "level the playing field," which, they say, has become "tilted" in favor of insurers and other large health care purchasers who use the threat of selective contracting to affect providers' rates or practice patterns. The antitrust laws simply do not condone such a collective effort by a group of competitors to "hold their ground" against market forces and other market participants.

The antitrust laws exist to maximize consumer welfare. Consistent with that goal, the Division strives to apply the antitrust laws in a way that will protect rather than impede emerging, potentially more efficient, health care delivery systems, so as to boost competition and reduce the cost of care to consumers. At the same time, we intend to challenge efforts by health care market participants, at any level, to unlawfully restrict the availability of competitive alternatives.

During the past year alone, the Antitrust Division has filed six health care cases: two hospital merger cases, two "most-favored nation" clause cases, a case concerning the exchange of wage information among competing hospitals and a recent case challenging a hospital network in Long Island, New York. Currently, the Antitrust Division is actively pursuing a number of other civil non-merger investigations in the health care sector.

In addition, particularly in the health care area, we have maintained a very close working relationship with state antitrust enforcement agencies. That relationship is reflected in two of the cases I described -- one hospital merger case filed jointly by the Division and the State Attorney General of Florida, and the other involving a most-favored-nation clause filed jointly with the

Attorney General of Arizona. We are also currently collaborating with state antitrust enforcement agencies in several other ongoing health care investigations.

While going to court to enjoin anticompetitive practices will always be an important part of what we do, both the Division and the FTC have also devoted substantial resources during the last year to assisting providers and other health care market participants in understanding how the antitrust laws operate in the health care sector, and how the federal antitrust enforcement agencies will respond to particular types of provider organizations or other collaborative efforts.

Two major steps in this direction are the announcement last September by the Department and the FTC of the revised and expanded health care Policy Statements, and our carrying through on the commitment we made in the original 1993 Policy Statements to provide an expedited business review/advisory opinion program for health care. The expedited business review program has been very successful. During the past two years, the Division issued 18 health care business review letters, and we have almost an equal number currently under consideration.

With that overview, let me now turn to two specific areas of antitrust enforcement. One of these areas is the application of the expanded 1994 Policy Statements to two of the most common emerging forms of collaborative provider organizations: price-setting physician networks (which we refer to in the Policy Statements as "physician network joint ventures"), and the formation of networks involving more than one type of provider (which we refer to in the Policy Statements as "multIprovider networks").

The other area I will talk about today is the Antitrust Division's recent enforcement activities concerning "most favored nation" clauses in agreements between health plans and providers.

II. The New Policy Statements

A. Background On The Expanded 1994 Policy Statements

In the fall of 1993, the Department of Justice and the Federal Trade Commission issued six statements of antitrust enforcement policy in the health care area, covering issues that we believed to be of greatest interest to the industry. Last fall, after numerous discussions and meetings with various representatives of the health care industry, the Department and FTC revised and expanded the 1993 Statements. The 1994 Statements address many of the comments that the agencies received on the 1993 Statements and also reflect our most recent enforcement experience. In drafting these Statements, we made a particular effort to address the unique problems posed by rural health care markets, where mergers, joint ventures, and other collaborative activities among providers might present difficult competitive issues because of the limited number of providers in the market.

I will focus first on the 1994 Policy Statement concerning physician network joint ventures.

B. Physician Network Joint Ventures

The shift to a competitive "managed care" marketplace has prompted many physicians who traditionally practiced alone, or as part of a small medical group, to band together and market their services collectively to managed care purchasers. Those physician organizations go by various names, such as independent practice associations ("IPAs"), "provider-controlled PPOs," or medical-society-sponsored "foundations for medical care." The Policy Statement

refers to such price-setting physician joint ventures generically as "physician network joint ventures."

The 1994 Policy Statement on physician network joint ventures contains three key elements: First, the Statement describes certain situations in which, absent extraordinary circumstances, the Department and the FTC will not challenge a physician network joint venture. (The Statement refers to those situations as "safety zones.") Second, the Statement establishes a financial risk-sharing requirement that a physician network joint venture must meet in order to qualify for the protection of the safety zones. Finally, the Policy Statement provides examples of how the Department and the FTC will apply, in specific situations, both the safety zones and the "rule of reason" analysis for physician network joint ventures that fall outside the safety zones.

1. The Safety Zones For Physician Network Joint Ventures

The Policy Statement provides a safety zone for "exclusive" physician network joint ventures comprised of no more than 20 percent of the doctors in the relevant market, and a safety zone for "non-exclusive" joint ventures comprised of no more than 30 percent of the doctors in the relevant market.

A physician network joint venture is "exclusive" if it significantly restricts the ability of its member-physicians to contract with managed-care customers outside the framework of the joint venture. This will be true if the rules of the joint venture require its member-physicians to contract only through the joint venture ("de jure exclusive") or even if the rules do not include such a restriction, but in practice, the joint venture's member physicians rely on the venture as their sole bargaining agent vis-a-vis managed-care customers ("de facto exclusive").

Conversely, if a physician network joint venture's members are, in actuality, free to participate in competing networks or to contract individually with managed-care customers outside the framework of the joint venture, it is "non-exclusive."

The Policy Statement provides a smaller safety zone for "exclusive" physician network joint ventures because they foreclose the member physicians from joining other managed care plans. That foreclosure is not necessarily a competitive problem in itself. For example, a collection of physicians that consistently contracts with managed-care customers as a unit may be able to achieve superior efficiency and quality controls. However, the prospect of an anticompetitive result clearly increases as an exclusive physician network joint venture's share of the doctors in a relevant market increases and thus reduces the pool of available providers that can be recruited by other competing managed care plans.

"In theory," it may be argued that a non-exclusive physician network joint venture will not have adverse market effects, even if it includes a large percentage of the physicians in a relevant market. This is so, the reasoning goes, as long as its member-physicians are truly inclined to compete with the joint venture by competitively contracting with payers outside the framework of the joint venture.

While that may be true in theory, it bears emphasis that a "non-exclusive" joint venture poses less risk of anticompetitive harm only if its member-physicians actually are inclined to avail themselves of the opportunity to secure business, on competitive terms, outside the joint venture. As a joint venture's share of the available physicians in a relevant market rises significantly above 30%, the risk also increases that the joint venture's member-physicians will be less inclined to see it in their interest to join multiple plans - and thus, in effect, compete

against themselves - and more inclined to stick with one relatively large joint venture. That may be true even in fairly advanced managed care markets, and is of particular concern to us in a local market that is still in the early stages of managed care development.

It is important to remember that physician network joint ventures that fall outside the safety zone do not necessarily present significant competitive concerns. Rather, as long as they comply with the shared financial risk requirement, or offer an efficiency-enhancing new product, they will be assessed under a rule-of-reason that will consider all of the characteristics of the venture and the relevant market, as well as the efficiencies created by the venture, to determine whether the ventures, on balance, are procompetitive or anticompetitive.

2. The Financial Risk-Sharing Requirement

To qualify for either the 20% or 30% safety zone, a physician network joint venture must satisfy a threshold "shared financial risk" test. To meet that test, the doctors who participate in the joint venture must share, among themselves, substantial financial risk that creates a shared incentive to operate efficiently.

While the Department and the FTC remain open to the possibility that new ways may be developed for meeting the shared financial risk test, the Policy Statement sets forth two basic examples of financial risk sharing. First, a physician network joint venture that enters into a fee-for-service agreement with a managed-care customer will meet this shared financial risk test if the agreement specifies cost-containment goals (e.g., a commitment to reduce the customer's health care expenditures, or the rate of increase in those expenditures), and includes a "risk withhold" provision under which the physician network joint venture will have to return to the customer a substantial amount of the compensation due to the participating physicians if the joint

venture as a whole fails to achieve the stated cost containment goals. Thus, the "risk test" seeks to ensure that the physician network's arrangements for sharing the rewards for meeting cost-containment goals, or the penalty for failing to do so, are such that each member will have not just an individual incentive to perform efficiently, but an incentive to work together to improve the performance of the physician network joint venture as a whole (including "policing" of over-utilizers and poor quality physicians).

The second example of financial risk-sharing that satisfies the Policy Statement's requirement is when the joint venture agrees to provide its services under a "capitated" (or per subscriber) compensation arrangement, which translates into the joint venture's members sharing the risks and rewards associated with that type of compensation agreement.

The rationale for shared financial risk is simple. Essentially, the Policy Statement is designed to encompass physician network joint ventures whose primary purpose is to achieve substantial efficiences or cost savings. Financial risk sharing ensures that the physicians participating in the venture share a clear economic incentive to achieve these savings.

C. Multiprovider Networks

Some experts believe that physician network joint ventures are just an interim development in the evolution of managed care markets, and that multiprovider networks that include both a physician and a hospital component - or, in some cases, a whole spectrum of other kinds of health care services and facilities - are the "next wave" in the evolution of competitive health care markets. While I can't predict the future, I can tell you that we certainly have been

hearing a great deal lately about physician hospital organizations ("PHOs") and integrated delivery systems ("IDSs"),

Instead of a policy statement and safety zone for multiprovider networks, the 1994 Policy Statements simply describe the analytical principles we will apply when we assess a multiprovider network. The Department and the FTC took this approach because we believe we need more experience in this area before we can comfortably articulate a policy statement and safety zone for these new types of arrangements.

Regardless of how many different types or levels of health care facilities or services a particular multiprovider network includes, a principal focus of our analysis continues to be the risk of competitive harm that stems from price-setting collaboration among horizontal competitors. For example, if the physician component of a physician/hospital organization engages in joint pricing activities, we will apply the analysis set forth in the Policy Statement for physician network joint ventures. Similarly, if a multiprovider network includes two or more hospitals that are viewed as competitive alternatives, we will apply essentially the same principles that we apply to mergers or joint ventures among hospitals.

In many instances a multiprovider network may be able to offer an attractive alternative delivery system to employers and other price-sensitive health care purchasers. For example, if managed care customers can choose between two or more attractive alternative hospitals to serve them in a given local market, then either hospital may be able to team-up with physicians on its staff to offer managed care customers an attractive multiprovider product in competition with other provider networks that serve that same market.

If, however, the network is able to achieve market power at either the hospital or physician level, it may use that power to exclude competing health plans from the market and restrict rather than expand the array of competitive alternatives available to consumers.

It is important to keep in mind that a network - whether a physician or a multiprovider network - that does not engage in joint pricing or agreements on other significant terms of competition need not necessarily limit the size of its network or be economically integrated. For example, competing physicians or other providers can avoid joint pricing by using an agent or third party to communicate with managed care customers regarding those physicians' individual fees, with safeguards to assure that the participating physicians are not in effect communicating or agreeing with each other about their fees. This arrangement - often referred to as a "messenger model" - may also facilitate customers' contract offers (including proposed compensation and other contract terms) to the participating physicians, to which those physicians respond individually, and independently of one another. The critical feature of a messenger model is that the agent or third party does not collectively negotiate on behalf of the physicians, influence the physicians to make or accept a particular offer, or in any other way serve to facilitate coordinated behavior among the physicians.

III. MFNS

Changes in the health care industry certainly have not been limited to doctors and hospitals. There also has been a proliferation of new forms of health insurance, and consolidations among health insurance companies. I cannot emphasize too strongly that we have scrutinized the activities of health insurance companies where warranted and will continue to do so in the future.

One insurer practice about which we have received numerous complaints is the so-called "most favored nations" or "MFN" provision that some health plans have demanded of the doctors, dentists, optometrists, hospitals or other health care providers that wish to serve on that health plan's provider panel.

Essentially, an "MFN" is a contract clause a health plan includes in its agreements with providers that requires the provider to give that health plan the benefit of the more favorable rates that the provider gives to any other health plan or purchaser.

Our experience to date with this issue suggests that MFNs are most likely to pose competitive concerns when the health plan that includes MFNs in its provider contracts has a substantial share of the health plan business in question (e.g., dental health insurance or vision health insurance), and its provider panel includes a large number of providers. The two cases the Antitrust Division filed recently on this issue best illustrate the adverse competitive effects that an MFN provision is likely to have in those circumstances.

Last August, the Division, together with the Arizona Attorney General's Office, filed a civil case against Arizona Delta Dental to stop its use of MFN clauses in its contracts with dental providers.

Delta Dental is a provider-controlled dental insurance plan that contracts with about 85 percent of all licensed dentists in Arizona. It also has a large share of the dental health plan enrollees throughout Arizona. Before Delta Dental began to enforce its MFN requirement, many of the dentists on its provider panel also served on the provider panels of other dental insurance plans, or offered their services to individual patients, at discounts of 25-40% off their usual fees. But when Delta Dental began enforcing its MFN provision, many of those dentists stopped

giving discounts to non-Delta patients, and resigned from competing dental plans, rather than face a reduction in the rate they received from Delta Dental. Thus, in addition to eliminating the discounts many consumers had previously enjoyed, Delta Dental's enforcement of its MFN requirement also impeded the entry of low-cost dental insurance plans.

A proposed consent decree prohibiting Delta Dental from using MFN clauses was filed at the same time as the complaint. The decree is designed to ensure that dentists who contract with Delta Dental are not deterred from negotiating independently with competing insurance plans, or from offering discounts to non-Delta-Dental patients.

More recently, the Department filed a case against Vision Service Plan challenging its use of an MFN requirement in 42 states and the District of Columbia. Like Delta Dental, Vision Service Plan ("VSP") required optometrists that wanted to accept its enrollees as patients to agree to an MFN provision in their provider contract with the plan. Because VSP accounts for a substantial portion of its providers' business, its enforcement of the MFN provision deterred the large number of optometrists who participated in VSP's provider panel from offering larger discounts to new, lower-priced Vision insurance plans, thus discouraging entry into the market by such plans. As in the Delta Dental case, a consent decree was filed with the complaint. That proposed decree currently is pending before Judge Jackson of the Federal Court here in Washington, D.C.

Some court decisions, such as the first circuit's 1989 Ocean State decision, have adopted a rather limited view of the circumstances in which an MFN provision violates the antitrust laws. We believe, however, that these clauses are harmful to consumers whenever they have the effects I have described with respect to the Delta Dental and Vision Service Plan cases. The Department has a number of ongoing investigations into MFN clauses around the country, and

we will continue to challenge such agreements whenever they are likely to have those anticompetitive effects.

IV. Conclusion

In closing, let me emphasize again that the health care industry is undergoing dramatic changes as it moves away from traditional indemnity insurance to selective contracting by larger, better informed, price-sensitive purchasers. These changes have made it possible for market forces to promote in health care some of the same cost-controlling benefits for consumers they have promoted in other sectors of our economy. Ultimately, those competitive market forces should help to restrain health care costs, while rewarding efficient, high-quality innovative health care providers. For that reason, I believe that competition, protected by sound antitrust enforcement, will continue to play a critical role in our evolving health care system.