FTC/DOJ HEARINGS ON HEALTH CARE AND COMPETITION LAW AND POLICY

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Health Care Remedies

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I. Introduction

It is an honor to participate in the FTC/DOJ Hearings on Health Care and Competition and Policy. The development of antitrust remedies often takes a distant second place to substantive antitrust law and, consequently, the federal agencies are to be applauded for giving remedy development the attention it deserves.

I am submitting a number of items with my testimony today including a number of consent judgments that I negotiated during my twenty years as an assistant attorney general in the Wisconsin Attorney General's office as well as a speech to the National Health of Lawyers Association meeting outlining the role of state attorneys general in health care antitrust enforcement. My opening remarks will be brief both because my submissions contain a substantial amount of detail that will go into the record of these proceedings and because I believe the most interesting part of this morning's session is likely to be the panel discussion.

II. Structural Versus Conduct Relief

The first question in remedy development is usually whether the most appropriate remedy is one which changes the structure of the industry involved, regulates the conduct of a firm or firms in the industry, or does some of both. The legal criteria for remedy formulation usually does not provide clear answers to this question in the context of a particular case. The case law provides that stopping the violation, preventing a recurrence of the violation and restoring competition are the goals of antitrust remedies. These somewhat contradictory criteria are often not helpful in answering the most basic question of whether structural relief or conduct relief is appropriate in a particular case.

The economists, of course, usually tell us that structural remedies change the incentive structure of firms such that compliance is more likely with less judicial monitoring than is

typically the case with conduct remedies that attempt to achieve the same outcome without directly altering incentives. For example, the structural component of the AT&T decree – separating the long distance business from the local telecommunications business – was regarded as a success because it changed the incentives of the constituent components of AT&T such that they perceived each other's turf as ready targets for increased rivalry through new entry. The line of business restrictions, of course were not generally regarded as effective in enhancing competition and also were difficult and somewhat expensive to implement.

This high level view of remedies from the perspective of industrial organization economics generally is not very helpful, however, when one is on the ground trying to find the correct remedy for a particular situation, especially when the likely outcome of the liability phase of the case is not clear to either side. For example, there is general agreement that divestiture is the preferred remedy in merger cases. The issue becomes considerably murkier when one takes into account litigation risk in merger cases. This, of course, is the question the federal agencies and state enforcers have had to face with respect to hospital mergers given the unsuccessful track record of federal and state litigation challenging hospital mergers.

III. The Practical Reality of Health Care Remedies

The history of hospital merger enforcement suggests that flexibility and humility are important virtues when dealing with remedies in health care markets. These markets are usually characterized by multiple lapses in the limiting assumptions and boundary conditions for perfectly competitive markets. For example, consumers typically do not pay directly for the services they use, consumers often have limited information with which to evaluate health care choices, health care services are heterogeneous, there is typically a small number of health care providers and health care purchasers in the form of health plans in any geographic area, and a

high degree of interdependence between various health care providers. The absence of any one of these limiting assumptions or boundary conditions for perfect competition means that it is extraordinarily difficult to predict the consumer welfare effects of the further relaxation of any particular assumption or condition. A merger that reduces the number of competitors by one or collusion which increases the coordination among buyers or sellers is likely to have adverse consumer welfare effects. The exact nature and extent of the adverse effect, however, is often difficult to predict in an environment where many of the other conditions for perfect competition are not met.

Remedy selection is also impacted by this reality. A merger that reduces the number of sellers by one - - especially a 2-1 or even 3-2 merger with difficult entry - - is likely to have adverse consumer welfare effects, everything else held constant. The most direct route in such a situation would be to litigate and prevent the merger. If divestiture is unobtainable, it is possible in certain cases that consumer welfare can be enhanced by ameliorating the effects of the reduction in the number of sellers by "fixing" other aspects of the market in ways that are likely to enhance consumer welfare. For example, requiring merging hospitals to pass on claimed efficiencies can enhance consumer welfare. Requiring hospitals to open their medical staffs and restricting tying of services may actually improve market performance beyond that in the pre-merger world. Each of these remedy provisions may have costs associated with them that must be balanced against the probable consumer welfare benefits.

As an antitrust enforcer for the state of Wisconsin, I entered into several consent judgments that incorporated certain conduct provisions in lieu of divestiture because they appeared to benefit consumer welfare. Because I have described these in detail in the material I

have submitted as part of the record here, I will not go into the details in the limited time available. In brief, these include the following:

1. State of Wisconsin v. Kenosha Hospital & Medical Center, 1997-1 Trade Cas. (CCH) ¶ 71, 669 (E.D. Wis. 1996)(Consent decree permitted merger conditioned on return of claimed efficiencies to consumers and restrictions on discriminatory and exclusionary conduct.);

2. State of Wisconsin v. Marshfield Clinic, 1997-1 Trade Cas. (CCH) ¶ 71, 855 (W.D. Wis. 1997)(consent decree permitted merger of multispecialty clinics but prohibited acquisition of additional primary and specialty care practices of varying periods and limits exclusive contracting and covenants not to compete.);

3. Wisconsin v. Wisconsin Chiropractic Ass'n., No. 01 CV 3568 (Dane County Cir. Ct. December 12, 2001) (an action charging WCA members with conspiring to increase prices for chiropractic services and to boycott third-party payers to obtain higher reimbursement rates, was resolved with a consent judgment requiring WCA to pay $62,500 in civil forfeitures and barring similar conduct and restricting activities of the WCA and its executive director in the future).

In each of these cases, the endpoint of the negotiations as reflected by the consent judgments reflected the parties' respective evaluation of their position in the litigation. A negotiated solution has the added benefit of not only reducing the risk of a complete shutout on remedies. For example, in the Marshfield matter, the state was able to obtain relief which allowed Marshfield to enter the Wausau area where it had virtually no presence prior to the merger, but to craft relief which prevented Marshfield from using its dominance in areas surrounding Wausau to "tip" the market for primary and specialty care in the Wausau area through additional acquisitions and hirings. This result appears to have enhanced competition in the Wausau area at the same time it allowed already strong health care entities in the Wausau area to adjust to Marshfield's entry and threaten Marshfield's dominance in the surrounding areas.

The consent judgment entered against the Wisconsin Chiropractic Association contains similar provisions that attempted to monitor and limit the ability of the WCA to coordinate the pricing behavior of its members. Although the verdict is not in on the effectiveness of this remedy, it was clear to the Wisconsin Department of Justice that sin-no-more remedy alone would not have been sufficient to deter future violations of the antitrust laws. The remedy, however, did not restore competition by rolling back price increases that were arguably related to the allegedly illegal conduct. It is doubtful that such relief could have been obtained through litigation given the stickiness of prices in health care markets generally.

IV. The Role of the State Attorney Generals

Such remedies entered into by state enforcers has been criticized as being too "regulatory." In some cases, the criticism is justified where relief not related to enhancing consumer welfare has been incorporated into such decrees. But such relief, for the most part, can be justified as an attempt to rectify the market failures present in many of the health care markets impacted by a merger or collusive conduct.

That state attorneys general would embrace such an approach is really not that surprising. As I have said elsewhere,[1] the interest of state antitrust enforcers in health care markets grew dramatically as state regulatory schemes were gradually dismantled over the past two decades. At one time or another, most states had some or all of the following regulatory structures familiar to anyone who has practiced in the health care area: certificate of need, certificate of public advantage, limitations on close panel plans, hospital rate regulation, direct controls on hospital mergers, and varying degrees of health care insurance regulation. Even as health care markets were deregulated at the state level over the past two decades, the long-standing market

[1] "Antitrust Enforcement in Imperfect Health Care Markets: A State Perspective," Keynote Address to the National Health Lawyers Association, Washington D.C., February 19, 1998 (Included as part of the record).

imperfections and non-market goals inherent in our mixed public-private health care system remained apparent to the state attorneys general.

This induced a multiple focus on the part of state attorneys general, some would say split personality, where the attorneys general began enforcing the antitrust laws with great vigor in health care markets at the same time their states continued to regulate and intervene in health care markets, often with the attorneys general in an advisory role. Attorneys general were and are required to wear multiple hats when dealing with health care industry including: representing in their Departments of Health; actively participating certificate of public advantage and CON processes; protecting the integrity of charitable trusts which run most health care institutions, especially hospitals; representing large university teaching and research hospitals and related physician groups; prosecuting health care fraud and abuse, defending state-employed health care providers in malpractice claims and; representing and advocating before state insurance commissioners and state legislators regarding health insurance matters.

In conclusion, the multiple responsibilities state attorneys general not only explain why they often are more receptive to remedies that can appear unconventional or too regulatory to the more specialized federal antitrust enforcement agencies. Perhaps, this focus is not only understandable but also defensible given the role of state attorneys general in representing consumers in their respective states. The local nature of health care markets suggest that state antitrust enforcement and consideration of broader remedies is likely to continue and, for the most part, its continuation is likely to be appropriate. On the other hand, the states cannot do this job alone. The existence of considerable expertise in health care markets at the federal level is an important asset to state antitrust enforcers.

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