Federal Trade Commission

HOSPITALS AND COMPETITION POLICY

MARY L. AZCUENAGA
COMMISSIONER

FEDERAL TRADE COMMISSION

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The views expressed are those of the Commissioner and do not necessarily reflect those of the Federal Trade Commission or the other Commissioners.

Good afternoon. It is my pleasure to be invited to discuss the Federal Trade Commission's antitrust enforcement efforts in the health care arena. As always, the views I express are my own and do not necessarily reflect the views of the Commission or any other Commissioner.

As I need not tell you, as hospital administrators, you are on the front lines of the debate about the increasing cost of health care and the public desire for access to good health care. We are constantly reminded that the costs of health care are increasing both for individuals and their insurers and, in the aggregate, as a percentage of the gross national product. Businesses that foot the bill for health care benefits are concerned about the impact of these costs on their ability to compete, and governments are struggling to pay the escalating bill for their health care programs.

I am not going to enter the debate regarding the cost of the delivery of health care services in this country and how to deal with it. That difficult problem is best left to the policy makers with expertise in the area. Rather, I will talk about competition in our predominantly private health care system.

Competition among health care providers and payers can be an important safeguard for consumers, particularly consumers' interest in obtaining quality care at a competitive price. The antitrust laws are designed to ensure that private restraints are not used to deny the benefits of competition to consumers.

I am going to divide my remarks about competition policy and health care into three general areas. In talking about the Federal Trade Commission's antitrust activities, I will first mention the kinds of cases we have been doing for the past fifteen years and then talk about some of our recent enforcement efforts involving horizontal restraints among competitors, particularly those that may affect hospitals. Second, hospital administrators have asked questions about the extent to which they can cooperate with competing hospitals. With those questions in mind, I will talk about the types of joint ventures that may be permitted under the antitrust laws. Finally, I will mention some recent changes in the Merger Guidelines that pertain to hospital mergers.

For about fifteen years now, the Federal Trade Commission has had a formal health care antitrust enforcement program. Our objective has been to eliminate private restraints that interfere with competition in the delivery or in the financing of health care arrangements. We try to safeguard for consumers the availability of different suppliers and services to the extent that the market demands them and to the extent that they are consistent with governmental regulations.

The Commission has challenged agreements among competing health care providers to restrict competition in a wide variety of settings. For example, the Commission has challenged coercive boycotts by physicians and other providers to prevent or deter new entry by competing health care professionals or facilities,[1] coercive boycotts to impede cost containment efforts,[2] and coercive boycotts to obtain higher insurance reimbursements.[3] The Commission has acted to eliminate certain restrictions that allegedly impeded the development of health maintenance organizations.[4] We have prohibited agreements among health care providers not to enter into innovative practice agreements, such as employment or other contractual relationships, and agreements not to practice in innovative settings, such as so-called "commercial" locations.[5] In certain situations, we have challenged concerted action to deny hospital privileges, when such action has been anticompetitive.[6] Of course, we have also

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[1] See, e.g., Sherman A. Hope, 98 F.T.C. 58 (1981)(consent order); Medical Staff of John C. Lincoln Hospital and Health Center, 106 F.T.C. 291 (1985)(consent order).

[2] Indiana Federation of Dentists, 101 F.T.C. 57 (1983), rev'd, 745 F.2d 1124 (7th Cir. 1984), rev'd, 476 U.S. 447 (1986).

[3] Michigan State Medical Society, 101 F.T.C. 191 (1983).

[4] Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979)(consent order).

[5] See, e.g., Oklahoma Optometric Ass'n, 106 F.T.C. 556 (1985); American Society of Anesthesiologists, 93 F.T.C. 101 (1979).

[6] Forbes Health System Medical Staff, n.4 supra.

prohibited efforts by competing providers to negotiate fees on a collective basis.[7]

Some antitrust concerns, such as agreements designed to exclude a new competitor or a new form of competition, seem to crop up time and time again. About a year ago, the Commission accepted consent orders against the medical staffs of two large hospitals in the Fort Lauderdale, Florida, area, and very recently we accepted for public comment an order against the chief of staff of one of the two hospitals.[8] The Medical Staffs of the two hospitals allegedly tried to prevent the Cleveland Clinic from establishing a regional operation in the Broward County, Florida area. The Cleveland Clinic delivers its health care services in a different manner from the traditional fee-for-service approach. As I understand the Clinic's approach, it offers surgery for a unit price that covers all services related to the surgical procedure.

According to the complaints issued against the medical staffs, when the Cleveland Clinic physicians sought to apply for privileges to admit patients to the two hospitals, the medical staffs unduly delayed any action on the applications and in some instances refused to provide the application forms. The medical

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[7] Southbank IPA, 57 Fed. Reg. 2913 (Docket C-3355, December 20, 1991); Preferred Physicians, Inc., 110 F.T.C. 157 (1988).

[8] Medical Staff of Broward General Medical Center, 56 Fed. Reg. 49,184 (Docket C-3344, September 27, 1991); Medical Staff of Holy Cross Hospital, 56 Fed. Reg. 49,184 (Docket C-3345, September 27, 1991), and Dr. Diran Seropian, (Docket D-9248, April 27, 1992).

staffs also allegedly tried to prevent the two hospitals from forming a joint venture with the Clinic by threatening the hospital with a walkout or a loss of patient referrals.

The consent orders prohibit the medical staffs from engaging in boycotts, threats of boycott, or other anticompetitive activity. This action cleared the way for the Cleveland Clinic to enter the Broward County market. Let me emphasize that the Commission does not necessarily endorse the Cleveland Clinic or the manner in which it prices its services. Our goal was to protect competition, and to allow consumers to decide whether they preferred that alternative.

Obviously, the Commission does not want to interfere with any legitimate effort by hospitals or nursing homes to contain costs. But certain activities of health care providers can raise antitrust questions. The Commission recently accepted a consent order relating to efforts by nursing homes collectively to boycott nurse registry services in order to prevent price increases.[9] The case involved six nursing homes in the Rockford, Illinois, area and registry services that supplied nurses to work on a temporary basis. The homes allegedly agreed to refuse to deal with one nurse registry service after it raised prices. The homes informed the service by letter that they would not use the service because they believed that its prices were excessive, and they also threatened to boycott other registry services if they raised their prices.

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[9] Debes Corporation, 57 Fed. Reg. 1736 (January 15, 1992).

The consent order prohibited the nursing homes from entering agreements to boycott a nurses registry or otherwise from agreeing to fix the prices charged by a nurses registry. The nursing homes were completely free individually to stop dealing with any nurses registry that charged too much. Individual actions were not at issue. The problem was that the homes had banded together and agreed to boycott the registry. Coercive boycotts to restrain competition in markets are a fundamental concern under the antitrust laws.

Some activities by physicians to resist the efforts of purchasers or payers to negotiate discounts or implement cost containment strategies may also violate the antitrust laws. For example, an organization may nominally take the form of a preferred provider organization (PPO) or an independent practice association (IPA), but the providers in the PPO or IPA may not in fact integrate their practices or financial arrangements. Such a "sham" organization does not offer a new or more efficient service. Instead, the providers merely use the organization as a vehicle to negotiate collectively with purchasers or third-party payers over prices and terms.

The Commission recently accepted a consent order against Southbank IPA of Jacksonville, Florida.[10] The complaint alleged that this IPA was organized solely for the purpose of negotiating higher fees for its physician members. The physician members of

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[10] Southbank IPA, Inc., 57 Fed. Reg. 2913 (Docket C-3355, January 24, 1992).

the IPA threatened collectively to resign from an HMO unless it increased their fees substantially. The HMO did increase the payments to physicians, and presumably passed along the increased costs to its subscribers in the form of higher premiums.

In the Southbank matter, the complaint alleged that the physicians did not jointly share any risk of loss. Nor did the IPA enable the physicians to provide services more efficiently. In short, the Commission had reason to believe that the Southbank IPA was a sham and was simply a mechanism for competitors, the physician members, jointly to decide on the price and terms of doing business with third party payers.

The consent order in the Southbank matter required the dissolution of the sham IPA. Absent a truly integrated joint venture, the order also prohibited joint negotiation of fees and terms of employment by the Southbank physicians.

The FTC's Bureau of Competition is currently investigating physician joint venture investments in medical facilities to which the investing physicians refer their patients. Since many of you probably do not follow the FTC regularly, I should explain a little about how the investigation process works. The Commission's Bureau of Competition initially seeks authority to use subpoena power from the Commission. If that authority is granted, as it has been in some of these investigations, the FTC staff investigates a possible law violation and at the conclusion of the investigation may recommend that a complaint issue. At that latter stage the Commission makes a decision whether to

challenge the conduct in question. The Commission has not made a decision in these cases, and the matters are still under investigation.

In a typical physician joint venture investment situation, a venture promoter might offer investment opportunities to the physicians in a community who can refer patients to the venture. There may be an explicit understanding that the investing physicians will refer their patients to the joint venture, but even absent an agreement, it obviously is in the interest of the physician investors to refer their patients since the patients of the investors are the main consumers of the venture's service.

Assuming that a large proportion of the referring physicians in a particular community become investors, the physician investors may in the aggregate have power over referrals. The FTC staff is examining the question whether such an aggregation of power to refer patients may violate the antitrust laws. At this point, I should emphasize again that the staff has made no recommendation on any of these cases, and the Commission has made no decisions.

Now let me turn to an area that some of you may have been particularly concerned about. Assume that there are two hospitals in a community, and each one offers a full range of services. With two competing providers, duplication of the services provided is probably inevitable, and sometimes hospitals may have some unutilized facilities or facilities operating at very low rates of utilization. A temptation may arise for the

hospitals to reach an agreement to rationalize their services, that is, to agree to eliminate some or all of the duplication in their service offerings.

An agreement between competitors to allocate markets has for a long time been regarded as a per se violation under the Sherman Act and Section 5 of the Federal Trade Commission Act. In my example of a two hospital community, the danger of such an agreement to consumers is fairly easy to see. Once the only competitor is out of the way, each hospital would have the power to increase prices without concern about the competition. But we should distinguish this situation from a joint venture to economize on certain types of support-related operations, such as a laundry or data processing. An agreement to consolidate some of these operations does not pose the same threat of eliminating competition in the provision of hospital services.

Although the antitrust laws do prohibit some agreements, we need not jump to the extreme conclusion that the antitrust laws prohibit any agreement or contact between competitors on any subject. That, I think, would be an unfortunate overreaction. The purpose of the antitrust laws is to protect consumers, and we recognize that some joint efforts may benefit consumers.

Hospital administrators sometimes ask whether they can jointly purchase a new device. A joint venture by hospitals to purchase a new device would not automatically be condemned under the antitrust laws. Such ventures can be efficient and may reduce the cost of care or improve the quality of care to

consumers. At the Commission, we apply a rule of reason analysis to determine whether a joint venture is legal. An inquiry of this sort is very fact specific, and depends on the competition in the community and the nature and purpose of the joint venture. Just because there is a question to evaluate from an antitrust perspective does not mean that in answering that question we will find a problem. I think that the Commission has been very attentive to the potential of joint ventures to save money and to bring new or improved services to consumers.

Joint venture analysis does require some digging into the facts and some thoughtful analysis, but antitrust enforcement should not be a barrier to efficient joint ventures. Of course, the analysis should smoke out shams such as the Southbank IPA that I mentioned earlier, which was an anticompetitive pricing arrangement in the guise of a lawful entity.

While I am on the subject of joint ventures, I should mention that Congress is considering legislation to extend the benefits of the National Cooperative Research Act of 1984 to production joint ventures. The 1984 statute gave special antitrust status to research joint ventures, and the proposed legislation would cover production joint ventures, which includes the "production or testing of any product, process, or service." The bill passed the Senate by a margin of 96 to one, which suggests strong bipartisan support. I understand that a similar bill is now out of the House Committee and awaiting further action.

I do not want to dwell on the details of the Senate bill because I am not sure whether this specific bill will become law. If the bill does become law, I am not sure that it will change the way the Commission approaches the analysis of production joint ventures because the bill provides for the use of the rule of reason standard that we now employ. Nonetheless, the bill provides some relief from treble damages exposure, and that may be important. It may provide a certain level of comfort to those parties who are contemplating joint ventures.

Overall, the message that I would like to convey to you as hospital administrators is that you should not assume that the antitrust laws prohibit all joint efforts. If you are thinking about a joint venture, and if your purpose is demonstrably to lower health care costs, to bring a new service to patients, or to improve quality, you should talk with your antitrust counsel about ways to accomplish that goal.

Now I would like to move from joint ventures to hospital mergers. The Commission and the Justice Department have challenged a number of mergers between for-profit hospitals over the years, applying the same standards under Section 7 of the Clayton Act that govern other corporate mergers. Recently, the Commission has challenged mergers of not-for-profit hospitals. The Court of Appeals for the Eleventh Circuit upheld our authority to do so in July 1991.

In April of this year, the Commission and the Department of Justice jointly issued guidelines stating the method of analyzing

whether to challenge a merger. These guidelines do not change the legal standards under Section 7 that apply in court, but they are an attempt publicly to describe our internal methods of analysis. I would like to mention two issues that the guidelines address and that commonly arise in hospital merger cases.

We often hear the claim that unless a merger is allowed, one of two merging hospitals will fail financially. This argument is presented as a defense or justification for a merger that otherwise appears to be anticompetitive. The rationale for the defense is that if a firm is about to fail and exit the market, an acquisition by a competitor is unlikely to be worse for competition than the failure. I should emphasize that although the Guidelines do not explicitly state this, the Commission and the courts have taken the position that the elements of the defense, which can immunize an otherwise anticompetitive merger, are strictly construed. I expect that will continue to be true. Under the new guidelines, the government will consider four points:

1. whether the firm will be unable to meet its financial obligations in the near future;

2. whether the firm will be unable to reorganize successfully under Chapter 11 of the Bankruptcy Act;

3. whether the firm has made unsuccessful good-faith efforts to find a reasonable alternative offer that would keep the firm's assets in the relevant market and pose a less severe danger to competition than the proposed merger; and

4. absent the merger, whether the assets of the failing firm would exit the relevant market.[11]

In most respects, this listing is similar to the predecessor version of the guidelines. The 1992 guidelines do eliminate a provision from the former guidelines on the "Financial Condition of Firms in the Relevant Market."[12] The section that has been eliminated led many firms to assert a variation on the failing firm defense that we sometimes called the "flailing firm" defense. A number of variations of the argument have been made, but the general thrust of the arguments has been that the merger should be allowed because of the weakened financial condition of one of the firms. These arguments have met with little success at the Commission, and elimination of the provision from the guidelines should help clarify our position on this matter.

I should observe that in merger analysis, the Commission does not totally ignore the financial weakness of one of the firms involved in the merger. The Court of Appeals in the University Health case offered some interesting observations in this regard.[13] In that case University Health Inc., the operator of a large hospital in Augusta, Georgia, was acquiring St. Joseph's Hospital, which was one of University's competitors.

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[11] Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines § 5.1 (April 2, 1992).

[12] Department of Justice, Merger Guidelines § 3.22 (June 14, 1984).

[13] FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991).

The Commission challenged the acquisition. Part of the Commission's affirmative showing was that the proposed acquisition would significantly increase the concentration of an already concentrated hospital market. The concentration showing was based on statistical market share data.

The merging hospitals argued that St. Joseph's was a weakened competitor. The court observed that the defendants could attempt to rebut the prima facie case by demonstrating that the market share statistics overstated the acquired firm's ability to compete, and, after discounting for the weakness, the merger would not substantially lessen competition. The court said that weakness as a competitor will be credited only in the "rare case" when the parties made a "substantial showing" that the firm's weakness required such a serious discounting of the market share statistics that the Commission's prima facie case was undercut and rebutted. In the University Health case, the court decided that the merging hospitals had failed to rebut the Commission's evidence that the merger would be anticompetitive. Notably, the hospital to be acquired had earned more in the year immediately preceding the proposed acquisition than ever before.

In hospital merger cases, the merging hospitals frequently argue that the merger would result in substantial efficiencies. The Commission has taken efficiency claims seriously for a long time, and considerable effort is often spent in evaluating those claims.

The new merger guidelines also revise the former discussion of efficiencies. The former guidelines explicitly stated that efficiencies must be demonstrated by "clear and convincing evidence." Since the guides generally are not intended to state evidentiary standards for litigation purposes, that language was deleted. I think it would be a mistake for merging firms to assume that this revision means that they can justify an anticompetitive merger with a fuzzy efficiency claim.

A major problem with efficiency claims is that parties often come in with vague and ill-defined "synergies" that they assert as benefits from the merger. That sort of unsupported claim is not very useful in assessing a merger. If merging hospitals really believe that the merger will result in substantial efficiencies, they should come to the Commission with a clear demonstration how specific economies will follow from a merger. An efficiency claim should be merger-specific in the sense that the efficiency cannot be obtained absent the proposed merger. I think that the Commission is receptive to such clear demonstrations of efficiencies, but in my experience such showings are rare.

A note of caution about speculative efficiency claims in hospital mergers may be appropriate in light of a recent article in Modern Healthcare.[14] The Justice Department challenged a hospital merger, but lost the case in court, based in part on

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[14] Burma, "The Aftermath of the Carilion Merger," Modern Healthcare 58 (February 10, 1992).

efficiency claims that had been advanced by the parties. The author observed that after the merger, prices have risen and many of the claimed efficiencies have not yet been achieved. The author also observed that the costs and time needed to accomplish the efficiencies were substantially underestimated, although some may eventually be achieved. I think the government agencies will continue to consider efficiencies, but also continue to exercise a healthy degree of skepticism in the face of efficiency arguments that are not supported.

Let me conclude with some very general observations. First, it seems clear that antitrust as applied to the health care area is here to stay. Second, remember that the Commission considers business needs and justifications in judging all but the most clear-cut offenses. We consider the reasonableness of conduct within the entire context in which it takes place. This standard and the Commission's exercise of its prosecutorial discretion provide a very real degree of protection for the many legitimate activities in which hospitals engage.

Thank you for your attention. Now I will be happy to take your questions.