CC: Melanne, Shirley



United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

May 13, 1993

Mrs. Hillary Rodham Clinton
1600 Pennsylvania Avenue
Washington, D.C.

Dear Madame First Lady:

I am writing to follow up on the antitrust issues that you have raised during recent health care briefings. Let me begin by reiterating my support for your tireless efforts to reform our unwieldy health care system. You have diligently undertaken the responsibility for one of the most important and challenging issues of our time and you have done a masterful job.

As you are aware from my questions to you and Ira at the Jamestown, Virginia briefing, I am particularly concerned about suggestions that the antitrust laws be relaxed for particular provider groups in order to speed health care reform. Both Senator Rockefeller and I have held hearings recently on this subject at which we have heard witnesses, including independent experts, federal and state officials, a trade association representing Health Maintenance Organizations ("HMOs"), and a nurse's union, among others, testify that relaxing the antitrust laws could undermine health care reform by increasing costs, retarding structural change, or disenfranchising nurses and other health professionals. Let me explain.

- Hospitals

The American Hospital Association ("AHA") has claimed that there is an inherent conflict between our health care policy and our antitrust laws. On one hand, health policy encourages hospitals to collaborate, while on the other hand antitrust enforcement threatens those collaborations.

Despite this apparent tension, the fact is that collaboration among hospitals, i.e., mergers and joint ventures, is not being stymied by antitrust enforcement. AHA's President

has publicly acknowledged that fact on more than one occasion.[1] Moreover, there is no cause for concern based on the enforcement record compiled by the Department of Justice's Antitrust Division or the Federal Trade Commission ("FTC"). Of the more than 225 hospital mergers that have occurred since 1987, only 22 have required second-request investigations and only 7 have been challenged. All but one of those challenges has been sustained and one is currently on appeal before the FTC. Moreover, there have been no federal challenges against joint ventures or buying arrangements among hospitals.

When I first became involved in this issue, the AHA's major concern with the antitrust laws seemed to be that it had created so much uncertainty among hospitals that it was chilling mergers and joint ventures. Hospitals had begun to believe that expensive legal opinions on antitrust issues were required for any type of hospital deal. They also felt that the enforcement agencies would not provide them with timely assistance on their antitrust questions.

Recently, however, the AHA has been more aggressive in suggesting that the antitrust laws need to be relaxed so that hospitals -- alone or in league with private parties -- can allocate markets for expensive medical equipment and services. At my March 23rd hearing on health care and antitrust, AHA's General Counsel, Tom Entin, suggested that hospitals should be allowed to divide markets by agreeing, for example, that one hospital would have the exclusive right to buy the area's only MRI and the other would have the exclusive right to buy the area's only lithotriptor.

I believe that the AHA's legitimate concerns about antitrust enforcement can be resolved without resorting to statutory changes in those laws. The Health Care Task Force's Working Group on Antitrust recommended a series of unprecedented administrative initiatives, which I endorse, to provide hospitals with more complete and more timely guidance on antitrust enforcement:

1. Expedited agency procedures for opinion letters on hospital deals;

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[1] For example, in a December 1991 interview with HEALTH NEWS DAILY, AHA President, Richard Davidson, referred to the problems created by antitrust enforcement as "more a perception than a reality." He also stated that "the whole thing has been blown out of proportion." Likewise, in the March 15th, 1993 edition of AHA News, Mr. Davidson was quoted as saying "[t]here is more [hospital] collaboration going on in communities than we ever imagined."

2. A joint statement by the agencies' explaining their enforcement policies on mergers, joint ventures and joint buying arrangements;

3. A compendium of the agencies' opinion letters and actions on specific deals available to providers on request; and

4. A basic primer on antitrust enforcement in health care available to providers on request.

These initiatives would provide hospitals with easily accessible and low-cost information about antitrust enforcement, and thereby eliminate any misperception that the antitrust laws prohibit procompetitive mergers, joint ventures or joint buying arrangements. Making this type of information readily available should also eliminate the need for expensive legal opinions on the kinds of routine antitrust issues that arise in hospital deals.

I am also confident that Anne Bingaman, who has been designated to serve as Assistant Attorney General for Antitrust, will provide the kind of leadership needed to assure that the administration's health care and antitrust policies work in tandem.

However, none of these initiatives is a substitute for vigorous antitrust enforcement against anticompetitive hospital deals. The fact is that the antitrust laws offer the only effective means that consumers have to assure that the benefits of a hospital deal are passed on to them, and are not hoarded by the hospitals in the form of increased profits or excessive reserves.

For example, a group of hospitals in Utah is currently under investigation for conspiring to allocate markets for pediatric services and for fixing nurses salaries. Although deals such as these may be in the hospitals' financial interest, they are not likely to benefit HMOs, nurses or consumers.

The point is that relaxing the antitrust laws would permit hospital competitors to make important business decisions based solely on their own best financial interests, and without regard to the best interests of the patients in their community. That is true whether the hospitals involved are urban or rural. In testimony before Senator Rockefeller, the Group Health Association of America, which represents HMOs, expressed the same concern about relaxing the antitrust laws. They warned that:

> Relaxation of the merger or other antitrust laws to permit blocks of providers ... to join together free of antitrust scrutiny would not only poorly serve HMOs ... but also would be a disservice to all purchasers of health care services including government, large and small employers as well as individual consumers.

● Doctors

I am also opposed to relaxing the antitrust laws for doctors groups. Doctors have an astonishing record of violating the antitrust laws going back to 1943 when they boycotted the formation of a Washington, D.C. HMO. Likewise, the American Medical Association ("AMA"), the trade association representing doctors, has consistently violated the antitrust laws by advising its members to refuse to deal with HMOs.

The antitrust exemption currently being proposed by the AMA would permit doctors to engage in the kind of per se illegal price-fixing that the Antitrust Division prosecuted successfully in UNITED STATES V. ALSTON, 974 F.2d 1206 (9th Cir. 1992), and thereby resist the demands of HMOs that they moderate their fees, which currently average $170,000.[2] In Alston, over 30 dentists conspired to increase their patients' out-of-pocket expenses for dental services.

The fact is that the antitrust laws allow doctors and dentists to negotiate collectively with HMOs if they are members of a group practice or a legitimate preferred provider organization, ("PPO"). To the extent that doctors have a legitimate complaint about antitrust enforcement, it is that the agencies have not been entirely clear about the rules that apply to such groups. However, that problem could be resolved by means of the administrative actions detailed above.

I do not believe that there is any convincing evidence that doctors need special statutory antitrust protection. And, I would oppose strongly any proposal that permitted doctors to price-fix, like the dentists did in the Alston case.

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[2] This is a particularly astonishing figure when you consider that primary care physicians and those practicing in rural areas make much less than that amount. For example, the Medical Group Management Association reported that family physicians practicing in groups of fewer than 10 physicians make an average salary of $89,000 a year.

● Drug Companies

I also have serious concerns about the Pharmaceutical Manufacturers Associations' ("PMA") request for immunity from antitrust prosecution for an agreement among its member companies to limit price increases. Senator David Pryor and I sent a letter to Attorney General Janet Reno urging her to reject the PMA's request, which I have attached to this letter.

My main concern is that the PMA is requesting immunity for a maximum price-fixing agreement that would not lower drug prices for most Americans, particularly the elderly. Under the PMA's proposal, drug companies could give large buyers deep discounts, which they could offset by increasing prices for individual buyers. They could also reduce prices on drugs for which they have competition and increase prices on drugs for which they have a monopoly.

However the drug companies chose to manipulate prices, the fact is that elderly persons are the most likely to be victimized by price increases. That is why the American Association of Retired Persons ("AARP") has opposed the PMA's request for immunity.

● Health Insurance Companies

There is one change in the antitrust laws that would benefit consumers -- repeal of the McCarran-Ferguson exemption, which would be limited to health insurers. This antitrust immunity allows health insurers to fix prices and the terms of coverage. The Health Care Task Force's Working Group on Antitrust recommended that the McCarran-Ferguson exemption be repealed in order to protect consumers from collusive price gouging by health insurers.

Specifically, concerns have been raised that health care reform could spawn a powerful cartel of health insurers that could dominate the new system. In that case, the antitrust laws would not protect consumers against price-fixing schemes or tying arrangements that would increase the cost of health care or limit coverage in other ways.

I believe that we should start the new health care system with a clean slate and eliminate special antitrust treatment for health insurers. Consumers and providers alike would benefit if those insurers were subject to our fair competition laws.

In summary, none of the groups seeking antitrust concessions have made a convincing case that American consumers would be better off if the antitrust laws were relaxed in their favor. In my view, relaxing the antitrust laws would simply encourage

provider groups to make decisions based on their own financial interests, rather than the best interests of their patients. The only change that we need to make in our nation's fair competition laws to benefit consumers is to repeal the antitrust exemption that allows health insurers to form tightly knit cartels.

I would welcome the opportunity to discuss these issues with you at your earliest convenience.

Sincerely,

Howard M. Metzenbaum
Chairman, Subcommittee on
Antitrust, Monopolies &
Business Rights

CC: Ira Magaziner
Judith Feder

Attachment

# United States Senate

WASHINGTON, DC 20510

March 18, 1993

The Honorable Janet Reno
Attorney General
United States Department of Justice
Washington, D.C.

Dear General Reno:

We are writing to follow up on a concern that Senator Metzenbaum raised with you during your confirmation hearing. The Pharmaceutical Manufacturers Association ("PMA") has requested a business review letter from the Department of Justice that would exempt its members from antitrust prosecution for certain price agreements. Specifically, the PMA has requested immunity to "set out a pricing policy by which member companies, acting individually and unilaterally, would agree to be bound." This policy would commit each PMA member to "limit its price increase, if any, on the entire line of its prescription drug products in any calendar year to an amount not to exceed the increase in the CPI." New drugs would not immediately be covered by this agreement.

Although we applaud the PMA for acknowledging publicly that action must be taken to bring down high drug prices, we do not believe that you should approve their request for special antitrust protection. First, PMA's request appears to violate established antitrust law that prohibits maximum price fixing. Second, PMA's proposal is not likely to be effective in lowering drug prices, and could increase prices for some consumers and many health care institutions. Finally, allowing PMA member companies to agree on price limits, for any purpose, could spill over into other markets, and thereby enable PMA member companies to resist the demands of large purchasers, such as Health Maintenance Organizations ("HMOs"), which have successfully negotiated price discounts. Allow us to explain each of these points.

The agreement for which PMA has requested immunity is similar in many crucial respects to the price fixing agreement condemned by the Supreme Court in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). In Maricopa, a group of physicians had agreed to maximum limits on the fees that they charged to patients insured under approved health plans. The physicians argued that their agreement was procompetitive, and hence not an antitrust violation, because it would allow them to "impose meaningful limit[s] on their charges," and to "provide

consumers of health care with a uniquely desirable form of insurance coverage that could not otherwise exist."

The Court rejected the justifications proffered by the physicians reasoning that "[e]ven if a fee schedule is desirable, it is not necessary that the doctors do the price fixing." The Court's central concern was that an agreement on maximum prices, even one undertaken for ostensibly procompetitive reasons, can become a "scheme [that] tends to acquire all the attributes of an arrangement fixing minimum prices."

Much like the doctors in Maricopa, the PMA argues that its price agreement should be immune from prosecution because it is procompetitive in that consumers would benefit from a limit on drug prices. The fact is that PMA's proposal does not assure a limit on drug prices for any purchaser. However, even if it did, there are more effective and less anticompetitive means that PMA can use to reach that goal. At its recent Board Meeting, the PMA itself proposed one such alternative:

> [T]he Administration [could] seek individual company commitments to restrain price increases. Ten leading manufacturers ... already have independently and voluntarily made public commitments to restrain their price increases to the Consumer Price Index. The PMA Board has urged the Administration to seek such commitments from other companies.

The second important reason for the Department to reject the PMA's proposal is that it could result in some purchasers paying higher, not lower, prices for prescription drugs. In its letter, the PMA states that the "effect" of the agreement for which it seeks immunity would be to permit drug makers to "limit the aggregate price increase for prescription drugs to amounts not exceeding the CPI." In other words, under their agreement, the PMA members would be free to raise drug prices in one market to recoup price reductions in another market. Consequently, consumers who do not obtain their drugs through an HMO or other larger purchaser, which can negotiate discounts from the drug makers, could find themselves paying higher prices.

Finally, the PMA agreement on price limits could spill over into other markets, and thereby threaten the recent increase in aggressive price competition in that industry. On March 11, the Wall Street Journal reported that "[f]or the first time in years, competition among drug makers is prompting some companies to try an aggressive marketing approach: lowering prices." Ciba-Geigy was reported to have slashed the cost of its new heart drug, Lotensin, by up to 50% below its competitors' prices in order to win HMO sales.

Competitive pressures have spurred cost-conscious private purchasers, such as hospitals, HMOs and mail-order pharmacies, to demand and to get deep discounts on drug prices. Under the PMA's proposal, there is a real danger that the maximum price increase that PMA members agree upon could become the only price at which a large purchaser could buy a drug. This would have the effect of increasing drug prices for institutions and undercutting efforts to promote price competition among providers, including drug makers.

We hope that you will agree that the PMA's proposal is simply not a viable solution to the problem of high drug prices and reject its request for an exemption from antitrust prosecution.

Sincerely,

Howard M. Metzenbaum
Chairman, Subcommittee on
Antitrust, Monopolies &
Business Rights

David Pryor
Chairman, Special
Committee on Aging