Responses to Written Questions for
FTC Bureau of Competition Deputy Director David Wales

Hearing on "Examining Competition in Group Health Care"
Senate Committee on the Judiciary
September 6, 2006

Questions from Senator Specter

1. **You indicated in your testimony that the antitrust laws allow physicians to act jointly, including by agreeing on fees, so long as their efforts produce significant efficiencies and the price agreement is reasonably necessary to achieve those efficiencies. What types of efficiencies would be significant enough? Under what circumstances would a price agreement be necessary to achieve those efficiencies? Have there been any cases in which the FTC has found such efficiencies?**

The FTC applies the same antitrust principles to arrangements in the health care industry as it does to arrangements in other industries. Accordingly, in evaluating joint pricing by competing health care providers, there are two threshold questions. First, have competitors economically integrated to create efficiencies, and second, is the joint pricing reasonably necessary to achieve those efficiencies? If so, then the joint price setting is evaluated under a relatively detailed rule-of-reason analysis to assess the net competitive effects of the arrangement.

With regard to the first question, the focus is on whether the competitors are engaged in a joint undertaking that is likely to enhance competition by, for example, reducing costs or improving quality. That is what is meant by an "efficiency-enhancing integration." Integration means a joint undertaking in which the competitors together can achieve something that they could not do individually.

The joint FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care and the FTC advisory opinions provide examples of some types of physician networks in which joint bargaining over fees has been deemed to be reasonably necessary to achieve significant efficiencies. These include various arrangements in which the network members share financial risk for the performance of the group as a whole, as well as arrangements involving what is sometimes called "clinical integration," in which the participants undertake various joint clinical activities to control costs and improve quality for the group as a whole. Moreover, the Health Care Statements emphasize that the examples are not meant to exclude other forms of integration that might also create efficiencies and justify joint pricing.

One example, a 2002 advisory opinion on a proposal by a physician group in Denver, Colorado, involved an arrangement designed to integrate the provision of primary and specialty services so that they are delivered in a coordinated fashion. It reflected a significant investment of time, effort, and other resources, and included the collective development and implementation of protocols and benchmarks with the potential to create significant interdependence among the physicians in their rendering of medical services. The physicians would pool their resources and expertise to identify common standards of care, and, through their agreement to abide by those standards, the physicians subjected themselves to the collective judgment of the group with respect to their patterns of practice.

The staff advisory opinion concluded that joint pricing was reasonably necessary to achieve the benefits of the arrangement because the key element of the arrangement for consumers was significantly dependent on the doctors being able to function as a group within which patients are commonly referred. The price for professional services rendered under health plan contracts needs to be established, and if it were done through individual negotiation and contracting, then no one could count on the full participation of the group's members.

Finally, the staff considered the extent to which the size of the group would create competitive concerns. It concluded that, as long as doctors were, in fact, willing to deal individually on competitive terms with payers who did not want the package product, as the group had represented, significant anticompetitive effects appeared unlikely.

2. **You suggest that collective action by physicians would increase the cost of health insurance for consumers, but wouldn't a lack of competition among health insurers do the same?**

Yes. Every effort should be made to ensure that both provider markets and insurer markets function competitively. Competition is fundamental to the nation's free-market economy, and it is an important tool for stimulating innovative strategies to control costs, increase quality, and provide consumer choice in health care. And antitrust enforcement plays a critical role in helping to assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. Allowing anticompetitive collective action by physicians is not the way to address competitive concerns regarding health insurers.

3. **You mentioned that the Health Care Policy Statements issued by the Department of Justice and Federal Trade Commission are intended to provide doctors with guidance regarding collaborative activities by doctors. Do you believe that there are any changes that could be made to the Health Care Policy Statements to help clarify when collaborative activity, particularly involving fees, is acceptable?**

While we are always willing to consider suggestions, the staff has no current plans to propose revisions to the Health Care Statements. I note that the Statements are only one form of guidance that the Commission provides to the public. The agency communicates in various other ways, including enforcement actions, advisory opinions, and speeches. Since antitrust analysis is inherently fact-intensive, looking at the way the agency applies established antitrust principles in specific, concrete fact settings can be the most informative. The staff is also mindful of the risk that greater specificity in the

Statements might serve to channel market behavior toward particular structures and discourage innovative, alternative approaches to health care delivery that might offer equal or greater efficiencies.

4. **Insurers assert that mergers generate efficiencies and reduce the cost of health care. Has the Federal Trade Commission considered holding companies to their promises – decreased premium growth rates, increased payments to physicians, and so on – as a condition of merger approval?**

Historically, health insurance mergers have been within the particular expertise of the DOJ Antitrust Division, so the FTC would defer to the DOJ on the subject of efficiencies generated by health insurance mergers. As a general matter, however, the Commission seeks structural remedies, such as divestiture, when it finds reason to believe that a merger poses a threat to competition. Remedies that rely on enforceable commitments to hold prices down, and similar regulatory decrees, are unlikely to adequately protect consumers, because they either can be evaded or can have unintended consequences. Moreover, a regulatory approach to an anticompetitive merger can present particular risks in the health care industry, because of the critical role that competition can play in prompting market participants to devise innovative strategies to address the cost and quality challenges facing the health care system today.

Questions from Senator Schumer

At the hearing, we examined the impact of consolidated health insurance companies on physicians. We did not, however, carefully examine the effect on hospitals. In New York, the consolidation of health insurers has been dramatic. We have recently seen the acquisition of Empire Blue Cross/Blue Shield by WellPoint, the acquisition of Oxford by United Health Group, and the proposed merger of the HIP Health Plans with Group Health Incorporated.

This activity exacerbates a disequilibrium, at least in my State, between the bottom lines of the health insurers and the bottom lines of our not-for-profit and public hospitals. For instance, last year the health insurance plans in New York State enjoyed a profit of $1.3 billion, while the hospitals have been in the red for seven consecutive years. Hospitals are held captive by huge national health plans, which need to sign contracts with plans like WellPoint, which has 34 million customers. And yet, our anti-trust laws prohibit hospitals from banding together to negotiate prices.

- **How can we expect a hospital to negotiate a fair deal with a behemoth like WellPoint?**
- **Should we amend our antitrust laws to allow struggling hospitals that serve our inner city, suburban, and rural communities to band together and negotiate fair payment terms with these huge national companies?**

An antitrust exemption to permit competing hospitals to engage in joint price negotiations with health plans is not the way to address any concerns about either the financial condition of hospitals or consolidation among insurers. Giving special antitrust treatment to price fixing by hospitals would raise costs to employers, patients, and health plans (both public and private); increase the ranks of the uninsured; and would not ensure better quality health care.

Many of the financial challenges facing hospitals today, particularly rural and inner city hospitals, are due to factors other than the payment rates offered by private health plans. Chief among these are: budget constraints on hospital rates paid by Medicare, Medicaid, and other public programs, which typically account for over half of a hospital's revenues; the costs of uncompensated care to uninsured individuals, now roughly 45 million people nationwide; and changes in health care delivery as more services are delivered outside of hospitals, in physician offices, diagnostic centers, and ambulatory care facilities. An antitrust exemption for collective fee bargaining would impose additional costs on the health care system while doing nothing to alter these fundamental underlying conditions.

With regard to disparities in bargaining power between hospitals and health plans, relative bargaining power varies from situation to situation, even when the plan is a large national company. In fact, in many instances it is the hospitals, not the health plans, that have greater bargaining power, because the plans need access to good, cost-effective hospitals in their networks in order to offer a product that is attractive to employers and consumers. Health plans' contract offers to hospitals must be sufficiently attractive that enough high-quality hospitals are willing to agree to the terms offered. Unless a health plan can assemble a network of providers willing to contract with the plan that is attractive to employers and consumers, the plan will have nothing to sell in the marketplace.

Anticompetitive aggregations of power on the buying side can be addressed under existing antitrust law. Promotion of competition at all levels of health care financing and delivery will serve the interests of consumers far better than antitrust exemption.