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FOREWORD

It is the tradition in the United States as in other industrialized societies to regard personal health care services as “different” from the vast majority of other goods and services. This difference derives from public concern about levels of private consumption by disadvantaged individuals and a widely held view that consumers are not well-positioned to deal effectively in health care markets, primarily because they lack the requisite knowledge. These beliefs have been responsible for the various important institutional arrangements that characterize health care—licensure of professionals and organizations, professional ethics codes, the dominance of nonprofit organizations in several parts of the health sector, public and private insurance, and the fee-for-service system. The lack of consumer knowledge meant that consumer trust was required. Such trust, it was argued, could not be maintained in a market in which buyers and sellers dealt with each other at arm’s length. If there was to be no market in the usual sense, then there was no role for market-perfecting policies, including antitrust scrutiny.

During the last decade and a half or so, there has been a major change in thinking about the roles of market forces in health care and in markets for professional services more generally, of the effectiveness of public regulation, and of the appropriate role of government as an antitrust enforcer. The changes have been reflected in legislative and judicial decisions as well as in the policies of public regulatory agencies. The new interest in competition as opposed to regulation in health care and other markets, such as airlines and banking, the reduction in special privileges for the professions, and the more limited role for government as an antitrust enforcer reflect both a new faith in the market power of buyers and a realization that public intervention also causes distortions. Sometimes the cure can be worse than the disease. Although there is to our knowledge no estimate of the frequency of antitrust suits by sector, the appearance of some continued antitrust activity in the health care field probably has much to do with the fact that antitrust is new in this field.

The growth in competitive forces in the health field is reflected in a number of important changes—increased market share of capitated health

plans with a corresponding decline in the fee-for-service sector, more employment-based cafeteria benefits plans, growth of preferred provider organizations, decline of entry regulation as embodied in certificate-of-need programs, advertising by hospitals, clinics, and nursing homes, and improved information on health care providers such as published mortality rates by hospital.

Recognizing the trend toward competition in the health care field and the changing role of antitrust enforcement as applied to health care and to other sectors of the economy, we convened a meeting of experts in antitrust and in health care for one day in Nashville in October 1986. Based on the meeting, we prepared a report which we later used as the basis for writing letters of invitation to participate in this symposium on antitrust issues in health care. Most of the issues discussed at the one-day meeting have been addressed by the authors of the papers in this volume. The authors added many others to the list.

To set the stage for the papers in this volume, and because the experts at the October 1986 meeting set a long-term agenda for research on antitrust enforcement in the health care field, we review some of the key conclusions of that meeting here. The topics that emerged from the meeting fall under these general headings: hospital peer review; hospital mergers and management contracts; managed health care plans; relationships among insurers and providers; state of competition in health insurance markets; quality-of-care issues; and technology assessment.

KEY ANTITRUST ISSUES IN HEALTH CARE

Hospital Peer Review. There is an increased number of cases involving a physician plaintiff against a hospital and members of its medical staff over the denial, limitation, or revocation of hospital privileges. In principle, peer review should allow a hospital's medical staff to safeguard quality by disciplining and even "weeding out" its "bad apples." Physician plaintiffs have argued that denial of privileges has been used as a mechanism for eliminating a competitor. Hospital peer review involves a number of issues. Should peer review be viewed as an activity by competitors with the effect of eliminating competition or an activity conducted by medical staff to safeguard quality, which is presumably in the hospital's interest as a competitor in the market for hospital services? Does the hospital board in reviewing the results of the deliberations of the hospital medical staff act in the hospital's interest or merely as a "rubber stamp" for the medical staff whose financial interest may be served by excluding a physician member? What have been the impacts of antitrust scrutiny of hospital peer review? What has been the cost of such litigation? Have suits inhibited meaningful peer review? Or have they made peer review fairer and less anticompetitive?

Hospital Mergers and Management Contracts. The hospital industry is being transformed from a "cottage industry" into one with fewer, horizontally-

integrated units. Although such consolidation may produce various efficiencies, there may also be a lessening of competition.

A number of economic and legal questions are evident. What are meaningful ways to define product and geographic markets in the hospital industry? Unique features potentially affecting market definition are the importance of insurance coverage for hospital care, the local nature of the service being provided, and the role of physicians as agents for patients in hospital markets. For various reasons, geographic markets appear to be widening as health maintenance organizations and others purchase care on a contract basis, sometimes at considerable distance from patients. Also, hospitals are increasingly providing services that previously were delivered by other organizations, such as home health care services and ambulatory surgery. What are the implications of these trends for product market definition? According to which mechanisms do hospitals compete? What is the role of price versus nonprice competition? Of referral mechanisms? To what extent do mergers result in economies-of-scale and of-scope? How do management contracts which have become increasingly prevalent in the hospital field during the last two decades fit into antitrust analysis? How should antitrust enforcement agencies deal with the downsizing of the industry that is currently occurring? For various reasons, hospital admissions and length of stay have declined in recent years leading to excess hospital capacity. How should the potential consequences of mergers of two or more hospitals in financial distress be analyzed?

Managed Health Care Plans. A “managed health care plan” is a loose term for a plan that seeks to achieve savings in health care costs by a combination of price reductions and improved management of health care utilization. One such organization is the preferred provider organization (“PPO”). Participants at our meeting noted that PPO’s may be organized by physicians in some localities to forestall growth of health maintenance organizations.

The following specific types of issues were identified by the experts. What are the major types of managed health care plans and where are the major potential points of antitrust concern? Since these plans often combine several stages of production, such as hospital, ambulatory, and home health care, there is possible concern about vertical restraints on competition. Since such plans sometimes enroll a large percentage of physicians in a market, there is also reason to worry about possible horizontal restraints on competition. At what market share is there reason to worry? What are other indicators of potential exercise of providers’ ability to act in concert, including pricing practices that may be considered to be “predatory”? The degree of integration of these managed plans is important for antitrust purposes. When joint pricing policies are established, should these policies be viewed as a cooperative activity of independent firms or alternatively as price-setting by an integrated firm?

Relations between Insurers and Providers. Physicians and other health professionals have not been granted an antitrust exemption accorded labor unions in pursuit of their collective self-interest. Thus, unlike unions, it is not possible for groups of physicians, dentists, and others to bargain collectively with private insurers. Under the *Noerr-Pennington* doctrine,¹ medical and other health care organizations are able to petition government agencies for changes in reimbursement that are judged to serve the collective interest of the petitioners.

The market power of some insurers, such as Blue Cross-Blue Shield in some states, may be sufficient to permit monopsonistic exploitation of individual sellers of health services. To the extent that monopsony supplants competition, there will be less output (and hence some patients may not receive beneficial care) and providers will earn lower incomes. Monopsony must be analyzed from the standpoint that the market has other noncompetitive elements. For example, under complete coverage, levels of health use may be too high. Some output restraint from monopsonies may be beneficial under certain circumstances.

Again there are numerous questions to be addressed: When an insurer with a high market share purchases services from practitioners in atomistic markets, what happens to price, output, and the qualitative aspects of services provided? How in turn are premiums affected? Does (or should) advice by a physician organization about fees such as coverage of a particular diagnostic or therapeutic procedure have first amendment protection? Where does one draw the line on threats by a practitioner organization that are made to elicit a desired response from a payer? Should *Noerr-Pennington* protection be applicable to negotiations with private decisionmakers? The rationale would be that some insurers, such as Blue Cross-Blue Shield, enjoy some state-conferred advantages. Are there grounds for reexamining *Noerr-Pennington* protection in cases involving concerted actions by groups of providers against a state agency, such as Medicaid?

Relationships between physicians, hospitals, and insurers have sometimes had the appearance of being too friendly rather than unfriendly. The best example is traditional hospital and physician involvement in the governance of Blue Cross-Blue Shield plans. What are the manifestations and consequences of such friendly relationships and what is the track record of antitrust enforcement agencies in dealing with them?

State of Competition in Health Insurance Markets. The market for private insurance in the United States includes insurers with a diversity of ownership forms. The nonprofit insurers derive certain state-conferred advantages, such as favorable tax treatment and in a few states inclusion in hospital rate-setting programs from which commercial insurer competitors are excluded. There are several issues to be addressed.

1. *United Mine Workers of America v. Pennington*, 381 U.S. 657 (1965); *Eastern R. Presidents Conference v. Noerr Motor Freight, Inc.*, 355 U.S. 127 (1961).

Which government policies may confer special advantages for certain types of insurers? How important is this source of competitive advantage? How have relationships between providers and insurers affected insurer market shares, such as the practice of hospitals granting discounts to certain insurers? What should be the posture of antitrust enforcement agencies to territorial restrictions preventing individual Blue plans from competing with one another in a particular geographic market? How should such agencies view combinations of insurance plans with providers, as occurs when a Blue plan sponsors a health maintenance organization? Has the antitrust exemption of insurers, McCarran-Ferguson,² outlived its usefulness? Does McCarran-Ferguson properly apply when insurers become providers?

Quality-of-Care Issues. Professional associations may undertake a number of actions under the guise of quality protection. For example, a medical society may take action against an individual physician on grounds of “unethical” conduct and/or on grounds of low-quality care. Professional associations have passed judgment on the qualifications of other types of practitioners, such as chiropractors and nurse-midwives, to perform certain types of care. Such associations may attempt to restrict the practice of these other practitioners in various ways, such as admonishing their members not to deal with the other practitioners and by preventing the other group from gaining access to their hospitals.

Under what circumstances is the public interest served when professional associations withhold information from the public? Examples include the identities of physicians who have been subject to a disciplinary action and information on adverse outcomes in hospitals, including hospital-specific mortality rates and rates of hospital-acquired infections.

When can bans on advertising promoted by professional associations be justified on quality-of-care grounds? Should provider boycotts justified for quality reasons be tolerated? Physicians with a certain practice style might be boycotted. A boycott may follow a reduction in Medicaid reimbursement. Under what circumstances are associations’ codes of ethics truly quality-enhancing?

When, if ever, should courts consider quality-of-care defenses in rule of reason analysis? If so, what are valid defenses?

Technology Assessment. Given the rapid pace of technological change combined with growing cost containment pressure on private and public payers, there will undoubtedly be increased demand for technology assessments to determine specifically which technologies are “cost effective” as well as “safe.” Professional associations and other organizations (for example, associations of equipment manufacturers) may want to conduct their own evaluations. Such organizations may fear that, with government’s role as a payer, government assessments may be biased against finding the new

2. McCarran-Ferguson Act, 15 U.S.C.A. §§ 1011-1015.

technologies to be effective. Or rather than seeking "truth," the motivation driving some private assessments may be anticompetitive in nature.

Private technology assessments could potentially be anticompetitive if such efforts were biased toward findings that placed certain groups of providers at a competitive advantage. Several pertinent questions arise. How should such private research be structured? How long should the organization be granted a monopoly for the conduct of such research, if in fact a monopoly is to be granted? How should the results be disseminated? Should the organization be required to supply pertinent material to permit replication by other groups. If the organization finds that a particular procedure, item of equipment, or technique is ineffective, what types of actions by the organization to prevent performance of the technology should be allowed?

Almost three years have elapsed between the date of the planning meeting and the publication date of this symposium issue. Although the issue bears a 1988 publication date, the material covered in the papers extends through early 1989.

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*James F. Blumstein
Frank A. Sloan*