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CLIENT ALERT

FTC/DOJ Report Pushes Competition for Health Care Industry Ills

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The Federal Trade Commission and the Antitrust Division of the Department of Justice ("the agencies") have issued a joint report on competition in the health care industry. The report calls for continued antitrust enforcement against anticompetitive activities in the health care industry, and recommends changes in state laws affecting health care markets, including certificate of need laws. The report, entitled "Improving Health Care: A Dose of Competition, was based on 27 days of hearings from February through October 2003, an FTC-sponsored workshop in September 2002, and independent research. The report and future antitrust enforcement prospects in health care was the focus of a teleconference and audio webcast sponsored by the American Bar Association's Antitrust and Health Sections and Center for Continuing Legal Education on August 31st and a brown bag lunch and teleconference sponsored by the American Health Lawyers Association Antitrust Practice Group on September 8th. Crowell & Moring's Art Lerner, whose hearing testimony is cited in the report on a range of topics, was a panelist in the AHLA program.

Concluding that "imperfections in the health care system have impeded competition from reaching its full potential," the agencies offer several recommendations for facilitating the financing and delivery of health care through increased competition. Among the more significant aspects of the report are:

Certificate of Need ("CON") Laws. CON laws have been prevalent since they were mandated by the National Health Planning and Resources Development Act of 1974. Although Congress repealed the Act in 1986, about 36 states and the District of Columbia still have CON programs. Some states favor CON programs because they give the state a measure of control over quality of care and access for low-income consumers, and constrain what some fear would otherwise be overbuilding. However, CON programs can also serve as a barrier to entry or expansion by hospitals and other facilities, and also by physicians who want to set up specialty hospitals or outpatient treatment facilities, such as kidney dialysis or oncology centers.

There is evidence that CON programs actually increase prices by creating barriers to entry into provider markets, since incumbent providers may use CON programs to forestall competitors from entering their market, according to the report. The FTC and DOJ believe that rather than containing health care costs, CON programs pose "serious anti-competitive risks that usually outweigh their purported economic benefits." Accordingly, the agencies recommend that states with CON programs rethink whether to keep them.

The demise of CON programs would facilitate the establishment of new programs, but could put heavy financial pressure on general acute care hospitals in some areas. In the absence of CON laws, however, states would likely seek to continue to exercise control over quality of care and access for the poor through increased state licensure requirements. A few states, moreover, also regulate rates for some categories of health care providers.

Collective Bargaining by Physicians. The report shows no signs that the FTC or DOJ will back away from vigorous antitrust enforcement against price fixing and boycott activities by health care providers. Some physicians have pushed for statutory

exemptions to the antitrust laws in order to permit independent physicians to collectively bargain. Proponents of such an exemption argue that collective bargaining is necessary to counterbalance payors' market power.

In response to this argument, the agencies maintain that effective antitrust enforcement should prevent payors from developing excessive power in the first place, and that collective bargaining by physicians will harm consumers by increasing costs. The agencies' belief that enforcement will adequately protect physicians' legitimate market interests coincides with the report's advocacy of consumer interests above those of health care providers or insurers, and the agencies' faith in their own capability to moderate unfair influences in the marketplace. The report therefore recommends against an antitrust exemption to allow physicians to bargain collectively. Physicians should also recognize that the report advocates aggressive enforcement -- including criminal antitrust cases – in appropriate cases.

Hospital Contracting Practices. The hearings included considerable discussion of the evolution of hospital – managed care contracting dynamics, including recent reports that some hospital networks and systems require that all hospitals be accepted in managed care networks and prohibit any type of variable copayment or other tiering mechanism as a means of discouraging high prices by hospital providers. Some hospitals may have "must have" status for provider networks, and various contracting practices may seek to help these hospitals and their owners exploit that status by obstructing efforts by health plans to take advantage of hospital competition to incentivize patients or providers to use more cost-effective hospitals. While the agencies apparently remain interested in these issues, and have investigation activity under way, the report itself does not plow new ground on these or other key issues. Instead, it summarizes the hearing evidence, but does not stake out new territory or outline any particular new enforcement paths.

Quality of Care Incentive Programs. The report includes a suggestion that arrangements within a provider network to reward quality and positive patient outcomes could in appropriate circumstances create the type of incentives that may permit providers to collaborate on pricing terms, where overall anticompetitive market effects are avoided. This comment shows the agencies' continued attempts to adapt their pronouncements on physician network contracting activities to provide flexibility, without backing off from their fundamental stance that "leveling the playing field" and similar arguments do not provide a justification for provider joint price setting.

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