PREPARED STATEMENT OF THE FEDERAL TRADE COMMISSION

Presented by
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before the

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

on

EXAMINING COMPETITION IN GROUP HEALTH CARE

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Mr. Chairman and members of the Committee, I am David Wales, Deputy Director of the Federal Trade Commission's Bureau of Competition. I appreciate the opportunity to appear today to discuss some of the Commission's activities to promote competition in health care markets.[1]

The FTC has long been actively involved in health care markets, and health care continues to be a high priority for the Commission.[2] The agency's fundamental goal has not changed: to ensure that health care markets operate competitively. As in the past, the agency will bring enforcement actions where necessary to stop activities that harm consumers by unreasonably restricting competition.

At the same time, the FTC is not solely a vigilant "cop on the beat" out to protect consumers from anti-competitive conduct. The agency works to promote competition through a variety of other actions, as well, including: providing guidance to market participants to help them comply with the law; undertaking and publishing studies, public hearings, and reports; and advising state and federal policymakers on competition issues in health care.[3]

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and responses are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

[2] Actions to promote a competitive health care marketplace have enjoyed bipartisan support within the Commission. *See, e.g.*, Deborah Platt Majoras, Chairman, Federal Trade Commission, "The Federal Trade Commission: Fostering a Competitive Health Care Environment that Benefits Patients," Remarks before World Congress Leadership Summit, New

Indeed, education – explaining antitrust policy to the industry and the public – is a key part of our mission. There is plenty of misapprehension and misinformation about the application of the antitrust laws to the health care marketplace, and the FTC activities and policies in this area. The agency works hard to keep the lines of communication open and our guidance up-to-date as markets evolve, and to provide additional guidance as new market structures and new forms of competition develop.

As part of its law enforcement role, for the past 25 years, the Commission has challenged naked price fixing agreements and coercive boycotts by physicians in their dealing with health plans.[4] These arrangements largely consist of otherwise competing physicians jointly setting their prices and collectively agreeing to withhold their services if health care payers do not meet their fee demands. Such conduct is considered to be "*per se*" unlawful because it harms competition and consumers – raising prices for health care services and health care insurance coverage, and reducing consumers' choices.

Not all joint conduct by physicians, however, is improper. Physician network joint ventures can yield impressive efficiencies. Thus, the FTC (together with DOJ) committed long ago to using a balancing test (in our legal parlance, the "rule of reason") to evaluate those physician network joint ventures that involve significant potential for creating efficiencies through integration. Physician joint ventures involving price agreements can avoid summary condemnation, and merit the balancing analysis, if the physicians' integration is likely to produce

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marketplace. *See* 71 Fed. Reg. 16779 (April 4, 2006).

[4] *See* Overview of FTC Antitrust Actions in Health Care Services and Products, available at http://www.ftc.gov/bc/0608hcupdate.pdf.

significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be *per se* illegal) are reasonably necessary to realize those efficiencies.

It is important to consider what can happen when health plans are forced to accept the collective demands of health care providers for higher fees that are not reasonably necessary to achieving significant efficiencies. The effect is not simply on the health plans that must pay more. Experience with antitrust enforcement over the years shows that the effects can extend to various parties, and in various ways, throughout the health care system:

- Consumers and employers face higher prices for health insurance coverage, potentially forcing some employers to reduce or drop health benefits for their employees.
- Consumers also face higher out-of-pocket expenses, such as increased co-payments.
- Senior citizens participating in Medicare HMOs (health maintenance organizations) may face reduced benefits, because Medicare pays HMOs a fixed amount per enrollee. Higher fees for professional services mean that health plans will have fewer dollars available to pay for benefits that are not available under traditional Medicare, but currently are provided by many Medicare HMOs.
- The federal government may pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health care programs.
- State and local governments may incur higher costs to provide health care benefits to their employees.
- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries may have to increase their budgets, cut optional benefits, or reduce the

number of beneficiaries covered.

- State and local programs providing care for the uninsured may be further strained because making health insurance coverage more costly can be expected to increase the already sizable portion of the population that is uninsured.[5]

For example, just two weeks ago, the Commission accepted for public comment a consent agreement involving two IPAs (independent practice associations) representing approximately 127 primary care physicians in the Kansas City area.[6] The consent agreement settles charges that the physicians refused to sell their medical services to certain health plans, except on jointly agreed-upon terms, including price terms, and that the physicians' actions were intended to raise or maintain higher fees. Further, according to the Complaint, the physicians' agreement and refusal to deal regarding their individua

traditional Medicare coverage, as an alternative for elderly consumers. In one of the counties, the plan was the only Medicare HMO available to elderly consumers. Thus, the physicians' actions would have eliminated any opportunity for consumers there to choose a Medicare HMO option. In the other county, the plan was one of only two that were available to consumers. The challenged activity would have eliminated consumers' opportunity to choose between the Medicare HMO alternatives for their coverage.

The FTC's experience teaches that this type of physician price-fixing and coercive collective activity in dealing with health plans – without any accompanying pro-competitive benefits – raises consumer health care costs considerably, without benefitting consumers. Unfortunately, this sort of harmful and unjustified behavior continues in the health care area, which is why the agency has been active in challenging this type of activity.

It is important to emphasize that collective setting of prices and negotiation with health plans by physicians does not assure quality health care, and there is no inherent inconsistency between vigorous competition and the delivery of high quality health care services. Theory and practice confirm that just the opposite is true – when vigorous competition occurs, consumer welfare is increased in health care, as in other sectors of the economy.[7] Interference with competition is far more likely to decrease consumer welfare. As the Supreme Court observed in *Indiana Federation of Dentists*, such interference necessarily and improperly preempts "the working of the market by deciding . . . that customers do not need that which they demand."[8]

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[7] *See generally*, Paul J. Feldstein, HEALTH CARE ECONOMICS (6th ed. 2004).

[8] *Indiana Fed'n of Dentists v. FTC*, 476 U.S. 447, 459 (1986).

As noted above, however, it also is important to remember that much joint conduct by physicians can be pro-competitive, and that neither the antitrust laws, nor the enforcement agencies treat it as an antitrust violation.[9] As pressure to control health care costs and assure quality continues, there has been increasing interest in encouraging efforts to achieve the efficiencies that can come about through cooperation and collaboration. Practically every week FTC staff hear about a new form of collaborative arrangement in the health care field, involving various combinations of providers, insurers, or other purchasers. Developments in information technology, for instance, present new opportunities for efficiency-enhancing integration among health care providers that are likely to increase efficiency and help assure high quality. Although these cooperative efforts often involve factually novel arrangements, antitrust analysis is sufficiently flexible to distinguish innovative, pro-competitive, market responses from collective efforts to resist competition. Indeed, potential efficiencies are one of the core issues in contemporary antitrust analysis, and this is true in health care, as in all sectors of the economy.

The FTC supports initiatives to enhance quality of care, reduce or control ever-escalating health care costs, and ensure the free flow of information in health care markets, because such initiatives benefit consumers. The Commission has no pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the marketplace, with physicians and other health care providers, and health plans offering alternatives that they

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[9] *See, e.g.*, Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, Federal Trade Commission to Gregory G. Binford (February 6, 2003) (staff advisory opinion stating that staff would not recommend that the Commission pursue law enforcement action with regard to a proposed program by physicians to publicize their concerns about the effects of reimbursement levels and other policies of health plans in the Dayton, Ohio, area.

The Commission staff also has provided considerable detailed guidance about potentially pro-competitive forms of physician integration. For example, over the years it has issued numerous advisory opinions concerning physician networks. In one notable instance, the staff issued a favorable advisory opinion to MedSouth in Denver,