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Antitrust Enforcement: Putting The Consumer First
by Howard M. Metzenbaum

Health care reform is long overdue. It is obvious to anyone who has ever had a seriously ill child or an aging parent in need of medical attention that the current system needs a complete overhaul. Indeed, the American people are so concerned about the inadequacy of our health care system that poll after poll shows that they are prepared to make significant financial and personal sacrifices to support comprehensive reform.¹

This marvelous spirit of sacrifice does not seem to be shared by the doctors, hospitals, and pharmaceutical companies that have profited so handsomely from the current health care system. President Clinton’s decision to convene a task force to tackle health care reform spawned a feeding frenzy among these provider groups for special-interest measures to, among other things, weaken our nation’s fair competition laws.

On 23 March 1993 I convened a hearing of the Antitrust, Monopolies, and Business Rights Subcommittee of the Senate Judiciary Committee, a subcommittee that I chair, to determine whether changes were needed in the antitrust laws to speed health care reform.² The subcommittee heard testimony from federal antitrust officials, legal scholars, individual providers, consumer organizations, and trade associations representing hospitals, doctors, and pharmaceutical companies.

What I learned at that hearing and since has convinced me that health care reform could falter if we relax the antitrust laws at the behest of these special interest groups or if we fail to repeal the health insurance industry’s statutory antitrust immunity.³ However, I agree with the provider groups that there is a pressing need for the federal enforcement agencies—the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission (FTC)—to clarify the antitrust rules that govern their enforcement decisions and to simplify and expedite the process for getting antitrust opinions on specific health care deals.

Howard Metzenbaum is a Democratic U.S. Senator from Ohio. Health Affairs invited representatives of the American Hospital Association, American Medical Association, Pharmaceutical Manufacturers Association, and Federation of American Health Systems to respond to Senator Metzenbaum’s comments; these responses follow.
Hospitals And Antitrust

The American Hospital Association (AHA) testified at the 23 March subcommittee hearing. The AHA’s major concern was that the antitrust laws had created so much uncertainty among hospitals that collaboration—mergers, joint ventures, and joint buying arrangements—was being “chilled.” Hospitals had begun to believe that expensive legal opinions on antitrust issues were required for any type of deal and that the enforcement agencies would not provide them with timely assistance on their antitrust questions.4

Despite the AHA’s concerns, there is little empirical evidence that collaboration is being stifled by antitrust enforcement. AHA President Dick Davidson has been publicly enthusiastic about the amount of collaboration among hospitals and has expressed skepticism that the antitrust laws are impeding collaboration.5 Moreover, there is no cause for concern based on the enforcement record compiled by the Antitrust Division or the FTC. Of the more than 225 hospital mergers that have occurred since 1987, only twenty-two have required second-request investigations, and only seven have been challenged.6 All but one of those challenges have been sustained, and one is currently on appeal before the FTC. Moreover, there have been no federal challenges to joint ventures or buying arrangements among hospitals.

At the hearing the AHA also expressed concern that the antitrust laws prevented hospitals from allocating markets for expensive medical equipment and services, alone or in league with private parties. Under the antitrust laws, market allocation per se is unlawful. Nonetheless, the AHA general counsel suggested that hospitals should be immune from antitrust prosecution for agreements that would, for example, give one hospital the exclusive right to buy the area’s only magnetic resonance imaging (MRI) device and the other the exclusive right to buy the area’s only lithotriptor.7 My problem with the AHA’s suggestion is that in the absence of antitrust scrutiny there is no reliable way to distinguish between an anticompetitive market allocation agreement and a market allocation agreement that would benefit consumers. In other words, giving hospitals broad antitrust immunity under these circumstances would leave consumers with virtually no protection against schemes by hospital competitors to divide the market for the purpose of monopolizing it and charging high prices.8

Despite my general skepticism about the hospital industry’s concerns, I believe that the AHA has raised legitimate concerns about antitrust enforcement against hospitals. However, these can be resolved without resorting to statutory changes in those laws. To that end, I have endorsed a series of administrative initiatives to provide hospitals with more complete and
more timely guidance on antitrust enforcement. These include (1) expedited FTC and Antitrust Division procedures for opinion letters on hospital deals; (2) a joint statement by the agencies clearly 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, which would be available to providers upon request; and (4) a basic primer on antitrust enforcement in health care, which also would be available to providers upon request.

These initiatives would provide hospitals with easily accessible, 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 also should eliminate the need for expensive legal opinions on the kinds of routine antitrust issues that arise in hospital deals.

However, none of these initiatives is a substitute for vigorous antitrust enforcement against anticompetitive hospital deals. Consumers can benefit from robust competition among hospitals and can be harmed by unnecessary consolidation. In a recent letter to the Clinton administration’s health care task force, David Dranove, a leading researcher in health economics, concluded that the economic research conducted in the 1980s suggesting that competition among hospitals led to a wasteful and costly medical arms race has “been soundly rejected by more recent research.”

Today, he continued, “medical markets work much like textbook economic markets, and competition is a force for lower prices, lower costs and higher quality.” Echoing those sentiments, Jack Zwanziger, a researcher at the University of Rochester Medical Center, warned that anticompetitive hospital deals could undermine the ability of competition to constrain costs:

Studies show that it is not just the presence of HMOs [health maintenance organizations] and PPOs [preferred provider organizations], but also of viable hospital alternatives, that are necessary to constrain hospitals [prices]. It is the ability to threaten to divert patients to a credible competitor that prevents hospitals from passing on their cost increases to consumers. No policy based on competition can succeed in the absence of such alternatives.

More recent economic studies, which examined the medical marketplace as it exists today, demonstrate that competition among hospitals will produce lower prices, lower costs, and higher-quality services. To that end, legislation relaxing the antitrust laws, and thereby permitting hospital competitors to make important business decisions based solely on their own financial interests, could undermine health care reform and send hospital prices through the roof.
Physicians And Antitrust

The American Medical Association (AMA) also appeared before the subcommittee. 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. And, according to the FTC, doctors have continued to violate the antitrust law with some frequency since then. For example, “[w]ithin the last two years alone, the Commission has issued a series of orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic.” The FTC also testified that the AMA itself has a history of violating the antitrust laws by, among other things, advising its members to refuse to deal with HMOs.

Nonetheless, the AMA has made specific legislative proposals to relax the antitrust laws that apply to physicians. As I understand it, the AMA proposal 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. It would thereby enable doctors to resist the demands of HMOs and other managed care entities that they moderate their fees, which currently earn them an average annual income of $170,000.

In defense of its proposed legislation, the AMA claims that “Alston demonstrates the need for reconsideration of the application of the antitrust laws to physician-payer negotiations.” In Alston, more than thirty dentists conspired to increase patients’ out-of-pocket dental expenses. James Rill, the widely respected assistant attorney general for antitrust in the Bush administration, called that case “a prime example of per se illegal conduct warranting criminal prosecution . . . [that was] wholly unrelated to the formation or operation of a bona fide joint venture.” In my view, legislation that would permit this kind of price-fixing activity among doctors or by the AMA would completely undermine health care reform.

The fact is that the antitrust laws allow doctors and dentists to negotiate collectively with HMOs and the like if they are members of a group practice or a legitimate 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, without any changes in the antitrust laws.

Drug Companies And Antitrust

The Pharmaceutical Manufacturers Association (PMA) appeared before the subcommittee to defend its request for immunity from antitrust prose-
cution for an agreement among its member companies to limit price increases. Prior to the hearing, Sen. David Pryor (D-AR) and I sent a letter to Attorney General Janet Reno urging her to reject the PMA's request.  

We opposed the PMA proposal for three reasons. First, it appears to violate the prohibition against maximum price fixing by health care providers that the Supreme Court reaffirmed in *Arizona v. Maricopa County Medical Society.* Second, it is not likely to lower drug prices for most consumers, particularly the elderly. Under the PMA 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.

Third, an agreement on price limits could spill over into other markets and enable PMA members to resist the demands of large purchasers for deep discounts. 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 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 increase drug prices for institutions and undercut efforts to promote price competition among providers, including drug manufacturers.

If the drug industry is serious about lowering prices, it can do so without special antitrust immunity. There is no reason that each individual drug company cannot make a public commitment to limit price increases-or even to roll back prices-and then stick to it.

### Health Insurance Companies And Antitrust

One change in the antitrust laws would benefit consumers: repeal of the McCarran-Ferguson exemption. This antitrust immunity allows health insurers to fix prices and the terms of coverage and to engage in elaborate tying schemes, whereby the sale of one product is conditioned on buying another product that a consumer would not otherwise buy.

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 could not protect consumers against insurer cartels that could increase health costs or manipulate coverage in other ways.

It is my view 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.
Concluding Comments

In summary, none of the groups seeking antitrust concessions has made a convincing case that American consumers would be better off if the antitrust laws were relaxed. In my view, relaxing the antitrust laws would simply allow provider groups to make decisions based on their own financial interests, rather than the best interests of consumers. The only change that we need to make in our nation’s fair competition laws to speed health care reform is to repeal the antitrust exemption that allows health insurers to form tightly knit, price-gouging cartels.

NOTES

1. For example, Consumers Union/Gallup Survey of 1,006 Respondents on Health Care, 26 March through 9 April 1993.
5. For example, in a December 1991 interview with *Health News Daily*, AHA President Dick 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 15 March 1993 edition of AHA News, Davidson was quoted as saying, “There is more [hospital] collaboration going on in communities than we ever imagined.”
8. The Federation of American Health Systems (FAHS), which represents more than 1,400 hospitals, has raised similar concerns, suggesting that market allocation decisions among hospital competitors could be made for the purpose of achieving a monopoly, reducing competition, and keeping others out of the market. Michael D. Bromberg, executive director, FAHS, written testimony for the Senate Finance Subcommittee on Medicare and Long-Term Care, 103d Cong., 1st Sess., 7 May 1993.
10. Jack Zwanziger, Department of Community and Preventive Medicine, University of Rochester, letter to Hillary Rodham Clinton, 14 May 1993.
14. 974 F.2d 1206 (9th Cir. 1992).
15. This is a particularly astonishing figure when you consider that many physicians earn much less. For example, the Medical Group Management Association reported that family physicians practicing in groups of fewer than ten physicians make an average salary of $89,000 a year.
18. Senator Pryor chairs the Senate’s Special Committee on Aging. Sen. Jim Sasser (D-TN), Sen. William S. Cohen (R-ME), and Rep. Fortney (Pete) Stark (D-CA) also sent letters to the Department of Justice opposing antitrust immunity for the PMA.