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Statement of

The Federal Trade Commission

Presented by

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on

S. 2051
Health Care Cost Containment Act of 1984

Committee on the Judiciary
United States Senate

June 26, 1984

Mr. Chairman, I would like to thank you for this opportunity to present the views of the Federal Trade Commission concerning S. 2051, the Health Care Cost Containment Act. S. 2051 would exempt from the antitrust laws and the Federal Trade Commission Act joint action undertaken among insurers and third-party payers of health care services relating to the collection and sharing of information and claims about such services, and also would exempt from these laws activities relating to third-party payers' joint negotiation of agreements with providers of health care services on charge levels and utilization of services.[1]

Containing the cost of health care services is one of the most urgent and important tasks facing our nation. It is a task that needs the energy and commitment of all segments of the society. We fully agree with the supporters of S. 2051 that health care insurers have an important role to play in health care cost containment. But, as I explain below, we believe that role can best be fulfilled through a healthy, vigorous, competitive rivalry among health care insurers, and not by reliance on

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1 S. 2051 would do more than merely exempt certain conduct from the antitrust laws. By including the Federal Trade Commission Act in its entirety within the scope of the statutory exemption provided in Section 4 of the bill, S. 2051, if enacted, also apparently would eliminate the Federal Trade Commission's consumer protection authority over unfair or deceptive acts or practices injurious to consumers, if those acts or practices arise in the course of information collection activities by any third-party payer or other conduct immunized by the bill.

an exemption from the antitrust laws. Therefore, because S. 2051 appears likely to reduce the very competition among insurers that helps assure their continuing efforts to contain costs, the Commission must respectfully oppose passage of the bill.

More specifically, and as I explain below, the Commission believes: (1) Current antitrust laws are no obstacle to the joint collection, analysis, and distribution of information needed for the purpose of containing health care costs. Sharing information is lawful, unless it reduces competition. An exemption for such conduct therefore is unnecessary. Moreover, the broad exemption created by S. 2051 in fact could injure competition and undermine cost control by immunizing information sharing in those rare cases in which it facilitates an anticompetitive boycott or collective price-fixing. (2) Collective negotiation by third-party payers with providers over health care charges and utilization -- that is, over price and output -- is likely to lessen competition and may well frustrate cost containment, by reducing the incentive among health care insurers and other payors to compete with each other in offering consumers cost-effective and attractive insurance packages. An exemption for such negotiation could, therefore, stifle the existing -- and growing -- incentives to compete and innovate, turning "the most natural candidates for the cost-containment job,"[2] into uniform actors with much less reason to compete with their fellow insurers in developing and implementing the most efficient cost

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2 Havighurst, Professional Restraints On Innovation in Health Care Financing, 1978 Duke L. J. 303, 320 (1978).

containment measures and benefit packages.

Competition and Antitrust in the Health Care Industry

Except as qualified by Section 5 of the proposed bill, S. 2051 would grant commercial health insurers and other persons that pay for healthcare services a special exemption from the antitrust laws. For convenience, I will use the terms "insurer" or "third-party payer" to describe the firms covered by the exemption. I want to emphasize, however, that the exemption would apply to all firms engaged in making payments for health care services. This includes commercial insurers, Blue Cross and Blue Shield plans, administrators for self-insured businesses, as well as health maintenance organizations ("HMOs") and other similar entities.[3]

The Commission has long supported the Congress's traditional reluctance to grant such antitrust exemptions, believing that "[t]he heart of our national economic policy long has been faith in the value of competition,"[4] and that the opportunity for consumers to freely select among alternative offers generated by such competition will assure that the highest quality product is available at the best price in the marketplace.[5] Special

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3 The bill also can be read as creating an exemption for healthcare providers. See note 12, infra.

4 National Society of Professional Engineers v. United States, 435 U.S. 679, 695 (1978), quoting from Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951).

5 See National Society of Professional Engineers v. United States, 435 U.S. at 695.

antitrust status should only be granted when there is compelling evidence that competition is unworkable or is incapable of achieving a paramount social purpose.6 The Commission submits that competition has an important role to play in the provision and financing of health care services, and is playing it with increasing effectiveness. Both the Congress and the Executive Branch have encouraged this trend toward increased competition, and have adopted several programs in the health care area that use competitive forces to improve efficiency and help control costs.

For many years competition was believed to be an inappropriate or insignificant force in the provision of health care services. Competition was discouraged among health care providers in a variety of ways, and the prevalence of third-party payment for medical expenses seemed to make the normal competitive market incentives somewhat irrelevant as the individual patient sought out medical services from the individual physician on a fee-for-service basis.

As it became clear that the continuing escalation of health care costs must be checked, Congress and the Executive Branch, along with the private sector, have become increasingly interested in permitting competitive forces to help provide a more efficient health care system. The Commission has shared and

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6 See National Commission for the Review of Antitrust Laws and Procedures, Report to the President and the Attorney General 177 (1979).

helped nurture this interest over the past decade. These efforts have focused largely on recognition that individual third-party payers have the incentive to contain costs when competing for subscribers, and that the large and increasing number of physicians and other providers and hospitals with unused capacity also have the incentive to attract patients by providing cost conscious care. Market forces can only be successful in helping to achieve cost control if vigorous competition exists among both those paying for health care and those providing it. Moreover, we believe that the antitrust laws can help assure that neither health care providers nor health care insurers frustrate those competitive forces.

Without cost control pressure from third-party payers, health care providers often do not have the incentive to cut costs significantly. Competitive rivalry among health care insurers and other third-party payers therefore is a fertile source to contain costs. Their special relationship with both providers and consumers of health care services gives third-party payers both incentives and opportunities to reduce costs -- by combining innovative benefit packages, utilization review mechanisms, and financing and delivery systems. Such innovation, however, is unlikely to happen without competitive rivalry among third-party payers. The need to attract and keep consumers through low premium levels and attractive benefits packages motivates insurers to contain costs. When the market for health care financing is competitive, those pressures to control costs

will be strong, as various plans -- commercial insurers, Blue Cross/Blue Shield plans, self-insuring businesses, and HMO's -- actively compete with each other in offering consumers cost-effective health care financing.

Cost containment incentives for third-party payers can be frustrated by either payer collusion or provider collusion. In the past, provider opposition has sometimes deterred insurer cost control initiatives. The Commission has actively used its antitrust enforcement authority to prevent concerted provider opposition to cost control efforts and to remove professional restrictions limiting cost-effective care. For example, in two cases last year, the Commission issued cease and desist orders to halt organized provider boycotts of third-party cost-containment programs, one aimed at insurer utilization review,[7] and the other at reimbursement rate decisions.[8] The Commission has also issued a comprehensive enforcement policy statement concerning the relationship of physician groups to medical prepayment plans and other health care insurers.[9] In addition, the Commission has closely monitored mergers of competing hospital chains, challenging mergers that it has reason to believe are likely

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7 Indiana Federation of Dentists, 101 F.T.C. 57 (1983) (Docket No. 9118), appeal docketed, No. 83-1700 (7th Cir. Apr. 1983) See also Texas Dental Ass'n, 100 F.T.C. 536 (1982) (consent order); Indiana Dental Ass'n, 93 F.T.C. 392 (1979) (consent order).

8 Michigan State Medical Society, 101 F.T.C. 191 (1983) (Docket No. 9129); See also Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

9 Enforcement Policy with Respect to Physician Control of Medical Prepayment Plans, 46 Fed. Reg. 48982 (1981).

either to give a competitor undue market power in a market for hospital services or to increase substantially the likelihood of collusion.[10] Finally, the Commission has sought to remedy several attempts by groups of fee-for-service physicians to obstruct competition from HMOs or other alternative - care institutions that employ, or contract with, physicians.[11]

The Commission's enforcement activity, along with similar private and government antitrust actions, and the pro-competition policies of the Congress and Executive Branch, have helped create a marketplace far more receptive to cost containment efforts by health insurers -- indeed it is a marketplace that now places a premium on cost-effective insurance. Those who finance and provide health care services have responded with a refreshing array of competitive and innovative plans and institutions. One promising example of innovation by both insurance carriers and providers is the creation of preferred provider organizations (PPOs), which can offer many of the cost control features of an HMO, while giving consumers a broader choice of providers.

This era of strengthened competition is still only a few

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10 See, e.g., American Medical International, Inc., Docket No. 9158, _____ F.T.C. _____ (Initial Decision issued July 27, 1983), appealed to the Commission (decision pending); Hospital Corporation of America, Inc., Docket No. 9161 (Complaint issued July 30, 1982) (administrative hearings begun Nov. 28, 1983).

11 See, e.g., American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982); Am. Soc'y of Anesthesiologists, Inc., 93 F.T.C. 101 (1979) (consent order); Forbes Health Sys. Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Serv. Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order).

years old. Yet, it seems clear already that competition can be an important impetus for containing health care costs, because individual third-party payers and providers are reacting with flexibility and imagination to consumer demand for cost-effective services and affordable financing. We have seen no evidence that individual third-party payers are unable to meet this challenge. More might be done on the legislative front to allow competitive forces to operate freely, so that competition will be given a fair chance to give Americans affordable and accessible health care, with a minimum of government regulation. As I will discuss more fully below, now is surely not the time to obstruct this experiment in health care competition or to slow down the competitive forces for cost containment by giving insurers an antitrust exemption to act in concert, rather than individually, in dealing with the cost containment challenge.

An Antitrust Exemption for Information Collection and Sharing Is Unnecessary

We concur with the premise underlying Section 4 of the bill that insurers and other payers may be able to implement more effectively cost containment measures if they attain access to better and more comprehensive information on the use and costs of health care services. Certainly the pooling and sharing of such information about the market could help insurers become more prudent "purchasers" of health care services on behalf of their insureds, and help insurers encourage cost conscious use of those services by both patients and providers. This type of joint information sharing activity is very likely to be procompetitive

-- and lawful under the antitrust laws as they now exist. Only in the rare situation when such an information-sharing arrangement was shown to have been established or used to further an anticompetitive boycott or collusive price-fixing would it be condemned under the antitrust laws.

Although we can understand the desire of insurers to obtain the greater protection from possible antitrust exposure that S. 2051 would appear to provide, we strongly believe that granting such a statutory immunity would be unwise. First, as I already have stated, we believe that such joint information gathering and sharing -- if done for legitimate cost containment ends -- is almost certainly lawful under the antitrust laws. Further, both the Federal Trade Commission -- through its advisory opinion procedures -- and the Department of Justice -- through its business review letter process -- can review any such proposed joint activity and provide formal, prospective evaluations of a venture's legality. Thus the potential antitrust exposure of such joint information sharing activity by insurers is more imagined than real.

We strongly question the wisdom of granting an antitrust exemption when it is not needed on the merits, merely on the theory that it will save insurers the expense of defending against groundless lawsuits. In fact, some members of the health insurance industry have been seeking this exemption for years. Yet to our knowledge, no insurer has ever identified a single information sharing program that could not be implemented because of antitrust risk. Moreover, the statutory exemption provided by

S. 2051 would appear to insulate certain joint activities that might take the form of information sharing, but which, in reality, might be undertaken for anticompetitive purposes or with anticompetitive effects. Thus, the exemption proposed by S. 2051 is not only unnecessary, but it also unintentionally could shield from the antitrust laws a variety of undesirable activities that undermine cost containment efforts.

An Exemption for Joint Negotiation by Third-Party Payers Would Harm Competition and Cost Containment

S. 2051 would exempt from the antitrust laws joint activity by insurers or other health care payers involving "negotiating, entry into or acting upon agreements with health care providers" with respect to the use of, and payment for, health care services. Although we understand that the bill seeks to facilitate cost containment by giving insurers more leverage in their negotiations with health care providers, the Commission submits that the more likely effect of the exemption will be to retard the economic incentives for each insurer to engage in vigorous cost containment by offering the public diverse, cost-effective financing in competition with other third-party payers. Economic incentives and competitive pressures are a far surer method for reducing costs than cartels or monopolies. An exemption that weakens those economic incentives is therefore more likely to frustrate than to facilitate cost containment.

As discussed above, individual third-party payers already have the clear economic incentive to encourage providers to reduce the costs of their services. Many large and small

insurers and other payers have accepted this challenge and already are offering innovative, efficient packages with premiums that attract cost conscious buyers. Individual third-party payers are finding efficient providers and together they are cutting costs, thereby putting competitive pressure on other insurers and providers to do the same.

The proposed exemption, however, would allow some, most or even all third-party payers in a market to bargain jointly with providers and to agree on reimbursement levels and utilization requirements.[12] Because reimbursement levels, utilization standards, and benefit coverages are all interrelated, uniform agreements on fees or utilization standards will encourage insurers to offer uniform products, both in benefits and prices, to the buyers of health care financing and services. Incentives will be lessened to offer a more attractive mix of price and coverage, or a better method of reducing high charges or excessive utilization levels. Competitive forces that currently reward innovation and diversity, and that result in individual insurers tailoring their products to the needs of particular segments of the public or of particular providers, will be severely reduced. In short, across-the-board coordination rather

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12 As noted above, Section 4 might also be read to mean that providers would be immunized from antitrust liability for joint negotiating over price and utilization levels. Such an interpretation would greatly exacerbate the problems discussed above. There is little reason to believe that monopsony power for insurers will solve the cost-containment problem; there is even less reason to hope that a monopolistic combination of providers negotiating with a monopolistic combination of insurers will do so.

than rivalry seems hardly likely to increase overall cost-containment efforts. Uniformity rather than diversity is hardly likely to serve the needs of consumers and employers.

Section 5(a)(2) of the bill would permit the Department of Justice, under some circumstances, to seek to prevent otherwise exempt actions that "have had the effect or will have the effect of increasing the cost of health care services or unduly restricting competition in the delivery or financing of health care services." Section 5 does not adequately fill the serious void in law enforcement created by Section 4 of the bill. It provides no role for the Federal Trade Commission to prevent either antitrust or consumer protection abuses. The bill preempts the states' antitrust laws, and deprives state attorneys general of their ability to use the federal antitrust laws to prevent anticompetitive practices against their citizens. The bill eliminates criminal antitrust prosecutions for even the most egregious conspiracies in the exempted area, and it leaves private parties with no legal recourse, so that providers will have no redress for financial injury. If insurers use the exemption to negotiate with providers in ways that raise costs, consumers will have no remedy to restore their losses, even if the Justice Department eventually halts a particular practice.

In addition, the authority left to the Department of Justice is unclear. The bill may create a new legal standard -- "unduly restricting competition" -- for enforcement by the Attorney General. By contrast, the Sherman Act has been interpreted to prevent "unreasonable restraints of trade," a term that has been

judicially defined through many years of antitrust law enforcement. Section 5 also gives the Attorney General responsibility to determine whether certain activities "have had the effect or will have the effect of increasing the cost of health care services . . . ." Again, this standard differs from that employed under the antitrust laws. If the intention is for the Attorney General to determine whether health care costs are "reasonable," the result could be costly and protracted proceedings similar to those of utility regulation.

Section 5 also appears to undermine one of the apparent purposes of the entire bill, i.e., eliminating or minimizing insurers' concern that certain joint activities designed to contain costs could expose the participants to antitrust challenge and liability. Because the standards for triggering the Section 5 exception to the bill's exemption are undefined and novel, this bill will still leave insurers with considerable uncertainty about antitrust exposure.

What the Commission and Congress Can Do -

The insurance industry undoubtedly desires to become more active and aggressive in health care cost containment. Moreover, some individual insurers may be frustrated with the apparently united front presented in many instances by health care providers. Although the perception of a monolithic and recalcitrant body of health care providers may, perhaps, have once had some validity, experience in the past several years shows that, in general, this simply is no longer the case.

The increased supply of health care providers -- empty hospital beds, new physicians with unfilled appointment slots, and emerging alternative forms and classes of health care providers (e.g., free-standing emergency centers, ambulatory surgery centers, etc.) -- is forcing providers to be more responsive to those who are paying for their services in order to attract patients. Purchasers, third-party payers, and providers of health care services have developed a variety of innovative programs to help control costs. Health care providers are becoming more cost conscious, and are organizing more efficient and innovative ways to deliver health care services. Such new concepts as PPOs and primary care networks, as well as HMOs, all have benefitted or been made possible by recent changes in the supply side of the health services market. The Congress itself has greatly aided this process, both through programs to expand the supply of health care providers and facilities and through its direction and support for innovative approaches to enable and encourage the government to become a more cost-conscious, prudent buyer of health services. These efforts should be continued and expanded.

In addition, the Commission and the Department of Justice, as well as numerous state attorneys general and private parties, have actively employed the antitrust laws to prevent health care providers from stifling cost containment efforts by insurers and others. The Commission is committed to vigorously pursuing its responsibilities in this and other areas. Health care providers know this, and thus insurers should be less likely to face the

concerted opposition to rigorous and innovative cost containment programs that they may have once faced. To the extent it can, the Commission also stands ready to challenge monopolistic restraints of trade by any third-party payer that unreasonably obstructs other payers' efforts to contain health care costs and compete in the market. Furthermore, as I mentioned previously, the Commission is able and willing to provide assistance, through advisory opinions and less formal advice from Commission staff, in order to help private parties avoid potential antitrust problems that might arise in their programs and activities. Continued congressional support for a strong antitrust presence in the health care area will help assure that the beneficial effects of competition attained to-date will be maintained, not eroded.

Finally, the Congress should attempt to eliminate specific, unnecessary obstacles to a more competitive health care system. Recently, the Commission endorsed removal of unwarranted state-imposed legal obstacles to the formation and operation of procompetitive, alternative programs, such as PPOs.[13] Not many years ago, the Congress enacted legislation to overcome state legislative obstacles that prevented the formation and development of HMOs, and to foster their development. Continued

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13 Letter from James C. Miller III, Chairman, Federal Trade Commission to Congressman Ron Wyden (July 29, 1983). See also Statement of George W. Douglas, Commissioner on Behalf of the Federal Trade Commission, Hearings on H.R. 2956: The Preferred Provider Health Care Act of 1983 Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 98th Cong., 1st Sess. (Oct. 24, 1983).

oversight and judicious intervention to remove unwarranted obstacles to competition also should facilitate insurers' cost containment efforts and help obviate the need to resort to exemptions from the antitrust laws.

Thank you very much for this opportunity to express the Commission's views.