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STATEMENT OF

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I am pleased to provide testimony at these hearings, and welcome your focus today on hospital contracting practices. I am an attorney in private practice in the health care field. My practice focuses on antitrust and other issues that arise in the interplay between health care providers, managed care plans and the government. From 1976 through 1985, I worked at the Federal Trade Commission, serving as assistant director for health care in the Bureau of Competition from 1982 to 1985. I work with both managed care plan and health care provider clients, more often the former. I am also Vice Chair of the American Bar Association Antitrust Section's FTC Committee, and Vice Chair of the Antitrust Practice Group of the American Health Lawyers Association. However, my testimony today is mine only, and I am not appearing as a representative of either of those organizations, or on behalf of any particular client or group of clients.

Hospitals across the country are doing excellent and innovative work, not only in patient care, but in fostering and enhancing the effectiveness of managed care programs in their communities. I believe most hospitals and hospital systems conduct their managed care negotiations properly and without running afoul of the antitrust laws. Some take very tough positions with payors. But hard bargaining and taking advantage of market position are not inherently anticompetitive or monopolistic. Further, hospitals are not required by the antitrust laws to grant discounts just because they are asked, or to negotiate discounts in the abstract, without regard to the benefit tier in the consumer's health plan that will be applicable to their services. Also, health plans certainly have tools of their own to use at the bargaining table. It is important to recognize, though, that while hospitals must struggle under many burdens, including the increasing cost pressures imposed by government and private payment sources, anticompetitive conduct is not an appropriate response.

The topic of today's hearing is hospital contracting practices in relation to competition and antitrust. I will focus on situations where antitrust concerns may be present. I should also note that today's topic is not contracting practices of managed care companies. That is a topic for another day – next month in fact.

Hospital Contracting Practices Which May Raise Antitrust Concerns

The contracting environment in health care markets varies across the country. Over the last few years, however, health plans and some providers have

increasingly voiced concerns that some hospitals are engaging in contracting practices that dampen competition, exploit hospital market power, raise costs, and reduce product options for consumers. These allegations appear to be particularly prevalent in states with large population centers where hospital competition has historically been vigorous, such as parts of California, Florida, Massachusetts, New York, North Carolina, and Ohio.

The alleged practices of concern take a variety of forms. I list only a few here:

1. That some hospital systems are demanding that health plans seeking an affordable contract from a particular hospital agree to also contract with other system hospitals that may be less desirable or less efficient or may not offer the same level of quality and reputation.

2. That some hospitals are requiring that a health plan seeking to include the hospital in the plan's provider network also contract for medical services through a physician network affiliated or aligned with the hospital, at prices higher than those the plan could otherwise get if physician services were purchased separately.

3. That some hospitals require, as a condition for contracting for their services, that a plan agree to contract for the services of the hospitals' owned or affiliated ambulatory surgery centers ("ASC"), home health agencies or durable medical equipment businesses at higher than market prices.

4. That some hospital systems are demanding that, in order for a plan to contract for any of the system's hospitals' services, the plan agree that all the system's hospitals, and all their services, be included in the richest benefit tier of every product the plan sells. Similarly, some systems are allegedly increasing the prices for <u>all</u> of their hospitals for plans that wish to put <u>any</u> of the system's hospitals in a lesser benefit tier.

5. That otherwise independent hospitals have formed a network to adopt common clinical pathways for patient care and are tracking their performance, with each hospital pledging to give money to charity if the individual hospital doesn't perform well in improving performance on these clinical measures, and on that basis insisting that the hospitals are entitled to jointly negotiate prices.

6. That some hospitals with local monopolies in some inpatient care services are using those monopolies to force plans seeking discounted rates from the hospitals to agree not to contract with providers of outpatient diagnostic or ambulatory surgery services that compete with the hospitals' own offerings.

7. That some hospital systems are linking contracts with hospitals that hold local monopolies to contracts with hospitals in more competitive markets, resulting in plans reporting that they are paying high prices not only in the monopoly market, but in the competitive market as well.

Such demands are sometimes made for providers within a closely controlled parent holding company system. In other cases, the providers may be included in a holding company of sorts, but the level of actual control for purposes of a *Copperweld* analysis is unclear. In still other instances, the providers may merely be aligned or affiliated in some way.

I can summarize here in more detail only how a few of these contracting practices may in some cases be employed and how they may be an advantageous way to exploit, maintain or expand market power.

In some situations, a hospital may see advantage in aligning a large proportion of the local physician community with it contractually or by ownership. There may certainly be vertical integration advantages to hospitals affiliating with physicians, but there can also be antitrust dangers.

Health plans in some instances depend on physician behavior to direct patients to more cost-effective hospitals. This is particularly so where the physicians share in the financial responsibility for the cost of hospital services to

patients in their care. Even where a hospital has some degree of market clout, changes in physician patterns of referrals and hospital privileges can influence patient flow patterns at the margins, and therefore encourage hospitals to be more price competitive.

However, if a hospital takes over the managed care contracting function for "aligned" physician groups this constraining aspect of physician behavior can be dulled. When the hospital controls the physicians' health plan contracting activity, the hospital may structure the physicians' contract to insulate the doctors from the cost of hospital care, and likely will forestall any efforts by the health plan to encourage expanded utilization by the physicians of other inpatient institutions. When the number of physicians affected is low, of course, these issues are not present, but as the magnitude of the affected physician population increases, the practical effect may be significant.

To bring physicians into the fold, some hospitals may be willing to use leverage to increase payors' compensation to physicians. This could help lock in physician referrals to deter poaching by other hospitals and steerage to other hospitals or providers by health plans and could also avoid physician compensation arrangements that encourage more cost-conscious use of hospital services.

In other situations, hospital systems may not only insist on high prices for hospitals that have a significant degree of apparent market power, but may also require that as a condition of doing business the health plan must also contract with other hospitals in the same system, in the same local market area or perhaps even

in another community in the same region, or with DME or home health providers controlled by the hospital system. The latter services may be at higher prices than the health plan might otherwise have secured. In addition, the inclusion of these additional system providers might prevent the managed care plan from getting deeper discounts from other providers willing to reduce prices for additional patient steerage. The hospital system might also impose explicit exclusivity requirements with regard to these separate lines of business or might condition pricing terms on volume requirements that achieve effective exclusivity. There might be legitimate business reasons, of course, for many hospital system contracting strategies so it is critical to avoid generalizations, in either direction.

Developing an Antitrust Enforcement Response

First, some basics are worth remembering. The *per se* rules have value. Also, the rule of reason should not be the marketplace equivalent of a hall pass – still stuck in school, but away from the authorities' effective reach. Antitrust loses valuable deterrent value if any set of competitors think that absent demonstrable market power or completely unadulterated price fixing they face little risk from collaboration in almost any form. Such views, in combination with case law defining hospital geographic markets very broadly, put consumers at risk.

This means, among other things, that the agencies should pay critical attention to all the component parts of joint venture analysis when considering

hospital collaborative ventures – not only whether there are likely to be efficiencies, but whether price fixing is reasonably necessary for those efficiencies to be achieved, and whether those efficiencies outweigh the risks to competition.

As for the geographic market and market power analysis in the first place, I can do no better in the time available than to relay anecdotal evidence – a discussion by a hospital executive with a health plan client recently, following a merger by the hospital with a nearby competitor. The hospital executive reportedly said, "According to the FTC, we don't have market power. But you know we do, so we will be demanding a much bigger price increase this year, and you know we are going to get it." And the hospital got the increase.

I also urge the agencies to use special care in evaluating efforts by some providers to justify price fixing activities on the ground that the providers are clinically integrated, when the integration consists primarily of joint adoption and pursuit of clinical pathways of care without actual consolidation of programs or meaningful collaboration in the care of individual patients. Consideration is needed for the level of clinical integration that will provide cognizable efficiencies and quality improvement. But there also must be great attention paid to the existence of a sufficient link between the clinical integration and the price fixing. That is, the agencies should consider why the hospitals need to fix prices in order to achieve clinical integration. If there is no such need, the clinical integration cannot justify the price fixing.

It is true that providers in risk sharing arrangements are generally able to negotiate price jointly for such arrangements. They continue to compete on price, though, for patients not covered by the risk sharing arrangements. This, of course, puts at least some market constraint – competition from themselves as individual providers – on the pricing associated with their joint risk contracting. By comparison, some hospital networks that purport to be clinically integrated may claim that the integration enables them to fix prices for all their contracts, even for health plans that would prefer to deal with the network's hospitals individually. This is markedly different than the circumstances underlying the joint venture approved last year in the *MedSouth* advisory opinion, where the affiliated doctors were willing to contract with health plans individually if the plans did not want to contract with the joint venture.

The agencies should also continue to recognize the dual levels at which hospitals compete and where consumers benefit from competition. Faced with quality and cost differences, an individual patient may be willing to travel considerable distance for certain hospital services. However, hospital price negotiation generally occurs at a different level – between the hospital and the health plan or insurer. In that negotiation, the health plan must be aware of the demands of its customer base, i.e., employers and consumers increasingly insistent on the health plan offering a broad choice of health care providers. For example, a health plan could not hope to succeed by offering a major employer in the

Washington, D.C. area a network that that had all the hospitals in the District of Columbia, but did not include any hospitals in suburban Maryland or in suburban Virginia, or vice versa, even though many individual patients would be willing to cross those borders to get their care.

Similarly, while a health plan might be able to drop a hospital in Falls Church and one in Gaithersburg from its network, or indeed could drop one, two, three or four suburban hospitals from its network, and still be considered a strong product offering for a major employer in the DC area, a plan that was missing nine or 10 hospitals might find itself viewed as offering a "low quality" product, that even a modest price reduction could not counterbalance. A network of hospitals of that size might thereby be able to exercise what would appear to be market power, even while by some tests it should not be able to. On this issue, as others, of course, the expression of the concern does not mean the harm has occurred or will occur.

Unlike the price of a radio being sold to Sears for resale to consumers, the high price of a particular hospital does not result in a significantly higher price to insured consumers for that hospital compared to others. The insurance effect that inheres in comprehensive health benefits programs means that the cost differences between hospitals, once they are included in the managed care network, are usually obscured from the cost equation for the individual consumer. Thus, while a hospital may impose a 15% or 40% price increase on the health plan, the individual consumer will not likely incur an equivalent increase in premium, and that increase

will not be associated in the consumer's mind with the particular hospital that charged the higher rates. The additional cost may be experienced as a more modest increase in health insurance premiums, and a relatively minor difference in copayment obligations.

Applying this type of perspective can help frame market power analysis, avoiding both under- and over-inclusive screens for market power.

Legal Tools

Tie-in analysis is one useful point of reference for some hospital contracting practices. The law declares, to simplify somewhat, that a tie-in is per se illegal when imposed by a party with market power. Chicago school economic theory tells us that a monopolist can typically only extract his monopoly rents once, so that it may be neutral from an efficiency standpoint if the monopolist foregoes monopoly profits in one product offering in order to extract higher profits with a separate product. We may find health plans perceiving that market power has been employed to make them pay more, and hospitals believing they are getting more, with the agencies trying to figure out, as a matter of theory, how and why this could be, and seeking empirical data to prove that it is true. We need to figure this out, fast. If it <u>is</u> true, perhaps we should not wait to figure out for sure <u>why</u> it can be true, but where harm is occurring apply existing law to stop it. Moreover, even if costs to consumers cannot be shown to be higher overall, there may still be reasons

to consider preventing this type of market manipulation, particularly if legitimate business justifications are lacking.

When health system organizations appear to be leveraging one or more hospitals' power to achieve better terms for other facilities or providers in the same system, is the hospital system collecting more monopoly rents through this activity that it could simply by raising the price of its core dominant service? It may be that the hospital system is able to spread the additional costs onto a different customer base – the health plan's customers in other towns or customers using other services – and thereby secure additional profits without sacrificing profits in the primary market power market. Demand curves may permit additional profit to be extracted in this way. For example, if employers in community A can be made to pay extra for health care on account of market power held by a hospital in community B, a hospital system may find it advantageous to leverage its power in this way. It other instances the conduct may actually help the system secure market power in market segments where it otherwise would face effective competition. The antitrust laws do not look with favor on such market manipulation if it can be shown that the party doing the bundling or leveraging has market power.

Tie-in analysis is not the only pertinent screen. Monopolization and agreement in restraint of trade case law is also instructive. The Third Circuit Court of Appeals' en banc opinion this week in *Lepage's v. 3M*, Nos. 00-1368 and 00-1473 (March 25, 2003) is illustrative. The Court confirmed that bundling price terms across different products to the same purchasers can be anticompetitive and

unlawful, even where the seller has neither charged below cost on the one hand, or threatened an outright refusal to do business, on the other.

Health plans can combat higher hospital prices to some extent through variable copayment plans – or "consumer choice" plans. These plans can, for example, impose different levels of copayment or deductible obligation for consumers, even as between participating providers. In this manner, the plan can maintain the higher cost hospital in the network, but consumers will have an incentive to use lower cost providers when practicable. These initiatives can have very real value, in making the cost of health care providers' services more transparent to consumers, and thereby trying to sharpen competitive focus. However, these programs have no competitive utility where there is no real hospital competition remaining. Also, the dominant provider may decline to participate in any such variable copay products, may seek to contractually bar the plan from ever putting any of the hospital system's providers in "second tier" benefit status, or may impose such severe penalties – across the whole system -- for such treatment of any part of the system, that the health plan has to forego the initiative as pointless. I am not suggesting of course that managed care plans should be protected by the antitrust laws from a hospital insisting on knowing what it is getting in exchange for price concessions.

More rudimentary competition problems occur in other communities. Some hospital executives reportedly share information on their managed care plan dealings in ways that may foster coordinated contracting strategies. Also,

competing hospitals may be represented by the same consultants or advisors, who then seek uniform changes in the terms of their clients' managed care contracts. If these advisors are not careful, antitrust lines may be approached and perhaps even crossed in some cases.

There are, of course, two sides to every story, and in some cases many sides. I have not, in the time available, explored today the reasons why various hospital contracting practices may in some instances have legitimate business justifications and how the marketplace in many circumstances can be self-correcting. There is, though, a critical role that antitrust must play in policing the marketplace, to ensure that competition and consumer choice are protected. This applies to provider conduct, as well as payor conduct.

Thank you for the opportunity to appear today. I hope my remarks today are helpful in consideration of these important issues.