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The views expressed are those of the Chairman and do not necessarily reflect those of the Federal Trade Commission or the other Commissioners.

Good afternoon. I am pleased to have the opportunity to talk to you today about the Federal Trade Commission's antitrust enforcement program in health care. While I will touch on several areas of enforcement in health care, including some recent developments, my comments today will focus primarily on physician network joint ventures. At the outset I should state that the views I express are my own, and do not necessarily reflect those of the Commission or any other Commissioner.

In the last twenty years, the Federal Trade Commission has had a vigorous, highly successful antitrust enforcement program in the health care field. This program has not been directed at, nor has it interfered with, legitimate professional self-regulation or physicians' development of new service delivery mechanisms responsive to consumers' desire for high quality and cost-effective medical care. Rather, the central purpose of the FTC's antitrust enforcement program is to rid markets of private behavior that unduly restricts competition without providing offsetting competitive benefits, and to prevent undue market concentration, so as to allow for consumer choice. The Commission has always placed a high priority on challenging cartel activities by providers and on anticompetitive hospital mergers. Given the dramatic changes in health care markets over the past few years, the Commission has devoted considerable resources to examining a variety of new provider arrangements whenever FTC intervention to eliminate anticompetitive restraints may foster competition and promote consumer welfare. Traditional areas of FTC enforcement activity have involved challenges against price fixing, boycotts and threats of boycotts, restraints on advertising and solicitation, and certain mergers.

Challenges against conspiracies among providers to establish or influence fee reimbursement levels have been, and will continue to be, a major FTC enforcement priority.[1] For example, in Michigan State Medical Society, the Commission held that the Michigan State Medical Society illegally conspired to obstruct the cost containment programs of insurers and the Medicaid insurance program through a group boycott to obtain higher reimbursement. The Commission found that the medical society obstructed insurers' cost containment programs by using a proxy campaign which allowed the society to collectively terminate its members' participation in third party payer and Medicaid insurance programs if these payers did not alter their cost

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[1] E.g., FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986)(cost containment program obstructed through dentists' concerted withholding of patients' x-rays); Michigan State Medical Society, 101 F.T.C. 191 (1983) (boycott orchestrated by medical society to affect payors' reimbursement policies); McLean County Chiropractic Assn, 59 Fed. Reg. 3114 (Jan. 20, 1994) (consent order governing alleged price fixing among

containment procedures and adopt reimbursement policies acceptable to the society.

The Commission has long challenged efforts by traditional, fee-for-service providers to exclude new types of competitors (such as HMOS, PPOS) from the marketplace through restraints of trade such as coercive boycotts.[2] In recent years, the FTC has taken enforcement actions against concerted actions among physicians to prevent the development of hospital-owned clinics or the entry of out-of-state, multi-specialty group practices into local markets.[3] The Commission also has challenged providers' threats or use of boycott tactics in order to increase their fees or obtain other forms of compensation.[4] For example, the Commission has provisionally accepted a consent order in Trauma Associates of North Broward, Inc., that would prohibit ten surgeon respondents in Broward County, Florida, from dealing with any provider of health care services on collectively determined terms, other than through an integrated joint venture. According to the FTC complaint, when the North Broward Hospital District refused to meet the respondents' unlawful, joint demands, the physicians in the group staged a walkout, forcing one of the trauma centers to close. The consent order requires Trauma Associates of North Broward, Inc., an unintegrated corporation used as the vehicle for collective negotiations, to dissolve, and prohibits the physicians from entering into similar agreements to reduce competition for their services in the future.

Another mainstay of the FTC antitrust program involves enforcement activity against concerted action among providers to ban or unreasonably restrict truthful, nondeceptive advertising

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[2] E.g., Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988) (consent order).

[3] E.g., Medical Staff of Broward General Medical Center and Medical Staff of Holy Cross Hospital, C-3344 and C-3345, 56 Fed. Reg. 49,184 (September 27, 1991) (consent orders governing alleged physician boycotts of the Cleveland Clinic); Medical Staff of Dickinson County Memorial Hospital, 112 F.T.C. 33 (1989) (consent order governing alleged physician boycott of hospital clinic).

[4] See Michigan State Medical Society, supra; Roberto Fojo, M.D., C-3373, 57 Fed. Reg. 9258 (March 17, 1992) (consent order prohibiting physician boycotts to obtain additional compensation from hospital for providing emergency room services); Trauma Associates of North Broward, Inc., 59 Fed. Reg. 42,051 (Aug. 19, 1994) (proposed consent order prohibiting physician boycott to

and marketing practices.[5] As you are aware, the Academy has had occasion to seek formal advice from the Commission on advertising and marketing restrictions.[6] In a 1983 advisory opinion, the Commission advised the Academy about the antitrust exposure that would arise from unreasonably broad interpretations of certain of its proposed ethical guidelines which ban communications that appeal to patients' anxieties or create unjustified expectations, misrepresent credentials, or contain material claims of superiority that cannot be substantiated. The Commission cautioned that care should be exercised to ensure that interpretations and enforcement of these rules do not have the effect of suppressing nondeceptive advertising or other such communications to the public.

The Commission has also had an active enforcement program governing hospital mergers. Before I go any further, I should note that most hospital mergers are procompetitive or competitively neutral, and therefore do not raise significant antitrust concerns. Although there have been hundreds of hospital acquisitions and mergers over the past decade, the Commission has challenged a small fraction of that number.[7]

The Commission has limited its enforcement actions to hospital mergers that are likely to be harmful to consumers, in the form of higher prices or lower quality. The Commission has successfully challenged anticompetitive acquisitions by for-profit hospital chains and by non-profit hospitals.[8]

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[5] See American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982).

[6] Academy of Ophthalmology, 101 F.T.C. 1018 (1983).

[7] See U.S. General Accounting Office, Federal and State Antitrust Actions Concerning the Health Care Industry (1994).

[8] American Medical International, Inc., 104 F.T.C. 1 (1984); Hospital Corporation of America, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987); Hospital Corporation of America, 106 F.T.C. 298 (1985) (consent order); FTC v. Columbia Hospital Corp., 59 Fed. Reg. 33,296, FTC Dkt. 9256 (consent order) (June 28, 1994); Columbia Hospital Corporation/Galen Health Care Inc., C-3472, 58 Fed. Reg. 65,721 (Dec. 16, 1993) (consent order); Columbia Healthcare Corp./HCA - Hospital Corp. of America, 59 Fed. Reg. 10388 (March 4, 1994) (consent order); Healthtrust, Inc. - The Hospital Company, File No. 941-0020 (proposed consent order) (July 11, 1994). The FTC has also challenged acquisitions by non-profit hospitals where the likely effect of the acquisition is to lessen competition. See, e.g., FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991); The Reading Hospital, 113 F.T.C. 285

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The Commission has also looked at new arrangements among providers when warranted. Health care markets are dynamic, and there are many new and different arrangements among providers that have emerged from the give and take of the marketplace. While many of these arrangements are procompetitive, some may foreclose competition and harm consumers. For example, the Commission has examined certain joint ventures in which otherwise competing physicians invest in a medical service facility and proceed to refer their patients to that facility. If the physicians in the venture are in a position to refer to the venture all or most of the patients in the community who are in need of the service offered by the venture, the aggregation of such "referral power" in the venture may be subject to challenge either under Section 5 of the FTC Act, 15 U.S.C. § 45, or Section 7 of the Clayton Act, 15 U.S.C. § 18.[9]

The Commission has given final approval to consent agreements in two cases involving joint ventures created by physicians to provide services that are ancillary to the physicians' professional practices. In both of these cases the joint ventures, which were set up as partnerships, provided oxygen delivery systems to patients at home. The home oxygen systems are almost invariably prescribed by, or under the direction of, a pulmonologist. According to the FTC complaints, approximately 60 percent of the pulmonologists in the partnerships, or practiced in groups with such investors. The complaints alleged that the physician-investors in each partnership, taken together, had market power in the market for pulmonary services and the ability to influence patients' choice of oxygen suppliers. By bringing together so many of the physicians who could influence patient choice, the partnerships obtained market power, created barriers to entry, and restrained competition in the market for home oxygen systems. The assets of the partnerships were divested, and the consent orders prevent the respondent pulmonologists from affiliating with a substantial percentage of local pulmonologists through any future ownership interests in home oxygen system suppliers.

Recently, there has been an emergence of local networks of hospitals, physicians, and other health care providers to market their services collectively to insurers, businesses, and other

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[8](...continued)
(1990) (consent order). The Commission has also issued for public comment a consent agreement involving the acquisition of outpatient surgery centers. Columbia /MCA, (proposed consent order) 59 Fed. Reg. 48883 (9/23/94).

[9] Home Oxygen and Medical Equipment Co., C-3530; Certain Home Oxygen and Medical Equipment Co., C-3531; Homecare Oxygen and Medical Equipment Co., C-3532 (consent agreements), 58 Fed. Reg. 220 (Nov. 17, 1993).

third party payors. In many instances, a provider network may be formed to achieve efficiencies and compete against unintegrated providers or other networks, and thus may be a procompetitive development that raises no significant antitrust concerns.

This past September, the Federal Trade Commission and the Department of Justice clarified their enforcement policy with respect to joint ventures, networks, and other joint activities in the health care industry. Under updated and expanded policy statements, the agencies will not challenge, except in extraordinary circumstances:

-- The collective provision by health care providers of non-fee-related medical data -- for instance, data about the outcome of a particular procedure -- that could help health care purchasers resolve questions about the mode, quality or efficiency of treatment; or the development of suggested standards for patient management in clinical settings.

-- Health care providers' collective provision of current or historical, but not prospective, fee-related information to health care purchasers, as long as the activity meets conditions designed to ensure that providers cannot share the information among themselves to coordinate prices or engage in other conduct that harms consumers. The policy statement goes on to caution that such collective provision of fee-related information by competing providers may not involve joint negotiation of, or agreement on, price or other competitively-sensitive terms by the health care providers, or involve any coercive collective conduct.

-- Participation by competing providers in surveys of prices for health care services or of salaries, wages, or benefits for health care personnel, as long as the activity meets conditions designed to ensure the data is not used to coordinate prices or costs.

-- Joint purchasing arrangements among health care providers, as long as they meet conditions designed to ensure they do not become vehicles for collusive purchasing or for price fixing.

-- An exclusive physician network joint venture (that is, a venture that restricts the ability of physicians to affiliate with other such ventures or to contract individually with health insurance plans), as long as the physicians share substantial financial risk and the venture comprises 20 percent or fewer of the physicians in each specialty with active hospital privileges in the geographic market. If there are fewer than five of one type of specialist in the market, the venture may include one of them on a non-exclusive basis.

-- A non-exclusive physician network joint venture (that is, a venture that does not involve limitations on the ability of participating physicians to affiliate with other ventures or to

contract individually with health plans), as long as the physicians share substantial financial risk, and the venture comprises no more than 30 percent of the physicians in each specialty with active hospital privileges in the geographic market. If there are fewer than four of one type of specialist in the market, the venture may include one of them.

The reason for the difference in the Commission's treatment of exclusive and non-exclusive physician network joint ventures is simple. Because it does not restrict the ability of its members to contract outside the venture, a non-exclusive venture is likely to allow for a greater number of competitors in a market, and allow new entry to occur more easily than does an exclusive venture. For this reason, the Agencies generally have less concern about foreclosure of competing plans if a venture is non-exclusive.

The new "non-exclusive" safety zone covers networks that are non-exclusive in fact, not just in name. Therefore, the Agencies have set forth factual indicia of non-exclusivity that will be taken into account in determining whether a physician network joint venture is truly non-exclusive.

I should also note that to qualify for either antitrust safety zone, participants in a physician network joint venture must share substantial financial risk. Joint ventures are to be distinguished from unintegrated provider cartels, whose sole purpose and effect are to raise prices and restrict output. A joint venture is characterized by some meaningful level of economic integration among the venturers that allows for a new (or improved) product or service to be offered through the venture. Acceptance by the network of capitation contracts, or the use of substantial fee withholds that provide real incentives for the provision of cost-effective care by members of the network, are examples of such economic integration. By contrast, "sham" organizations sometimes are formed by competing physicians, the sole purpose of which is to negotiate jointly over price in order to resist the efforts of third party payors to obtain discounts or implement cost containment strategies. These arrangements may take the nominal form of an independent practice association (IPA), but let me note again that the Commission examines the substance rather than the form of any such arrangements. Unlike a legitimate IPA, however the physicians have not substantially integrated their practices or financial arrangements.[10]

I cannot emphasize enough that physician network joint ventures that fall outside the antitrust safety zone do not necessarily raise substantial antitrust concerns. Indeed, joint

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[10] See Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order); Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order).

ventures that contain a higher percentage of physicians in a relevant market than the percentages falling within the respective safety zones can be competitively neutral or procompetitive. Physician network joint ventures not covered under the ~~safe~~ty zones will be reviewed under a rule-of-reason analysis, which balances the likely procompetitive effects of the venture against its likely anticompetitive effects. The venture typically will not pose a significant antitrust risk if the market shares of the participating providers are not so large as to foreclose competition; if the venture creates substantial efficiencies; and if any ancillary restraints imposed by the joint venture are reasonably necessary for the venture to achieve the efficiencies.

Antitrust issues would arise where the purpose and effect of the network is essentially to eliminate or reduce competition among providers. For example, a network composed of all or virtually all of the providers in the market could be deemed to be a discount-resistant, "united front" against purchasers. [11] A network that "ties up" most or all the primary care physicians or specialists of a particular discipline, through long-term exclusive contracts or otherwise, may foreclose competition and invite antitrust scrutiny. Still other antitrust issues may arise where there appears to be little economic integration among otherwise competing providers in the network, so as to cast doubt on the purported efficiency-enhancing function of the network itself. [12]

These policy statements reflect the Commission's continuing effort to provide guidance and to reduce unwarranted fears that could stand in the way of conduct that benefits consumers. The Commission has committed to providing advice to health care providers on proposed non-merger matters on an expedited basis. The Commission and its staff stand ready to work with professional groups and individuals to reduce antitrust uncertainty and to facilitate understanding as to the scope and nature of antitrust enforcement concerns.

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[11] See DOJ Press Release re: Stanislaus Preferred Provider Organization (Oct. 12, 1984).

[12] Compare Letter to George Q. Evans from Mark J. Horoschak (July 5, 1994) with Letter to Paul W. McVay from Mark J. Horoschak (July 5, 1994).