The Essential Role of Antitrust in a Competitive Market for Health Services

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THE PROSPECTS FOR ACHIEVING COMPETITIVE reform of the health care industry have never been better. Members of the new administration appear to be comfortable with relying on competitive forces to police markets, and they eschew command-and-control regulation whenever possible. Moreover, the new Republican majority in the United States Senate may significantly enhance the ability of procompetition health reformers, like Senators Robert Dole and David Durenberger, to develop and enact the necessary legislation. Whether this general orientation toward economic regulation will be applied to the health care industry remains to be seen, but it is probably safe to assume that the White House and the Ninety-Seventh Congress will be more receptive to competition proposals, particularly those that modify current methods of financing health care, than were their predecessors. The purpose of this paper is to explain why antitrust is an essential element in any serious attempt to make this market more competitive.

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What Does Competition Mean in This Industry?

Competition is the latest "buzz" word among health policy makers. Yet, few people interested in health care really understand what it means to "rely on the market" because they have been thoroughly conditioned to believe that normal market forces do not, perhaps cannot, exist in this industry. The penetration of insurance, the pervasiveness of state and federal regulation, the ignorance of consumers, and the life-and-death nature of medical care are the most frequently articulated reasons for why competition won't work. Others have discussed these factors at length, so they will not be reviewed here. Suffice it to say that competition in this industry is not a widely accepted concept. Despite the uncertainty about eventual adoption of competitive health care reforms, many planners, professional associations, hospitals, and insurers are trying to figure out how competition will affect them and what they can do to shape its evolution.

Competition advocates like Alain Enthoven and Walter McClure have emphasized basic structural reform, particularly changes in financing, and have studiously avoided getting mired in the details of how competition would actually work. This reflects an orientation that values establishing certain conditions and procedures favorable to the development of market forces and then relying on those forces to regulate price, quality, and access. This is a marked departure from a regulatory approach, which would establish desired outcomes and specify each step along the way toward attaining them. It may be helpful to think of competition as a state-of-being rather than as an end: one has to assume, in the absence of compelling evidence to the contrary, that the end product will be preferable to what we have now. At best, acceptance of competition in the health market requires skeptics to give it the benefit of the doubt. There can be no guarantees in advance that it will produce what its advocates claim.

The proposed structural changes fostering competition are basically quite simple and few in number. Enthoven's consumer choice health plan consists of: (1) changing the tax code to equalize government subsidies among all competing health plans, probably through a limit on the deduction an employer can take for this expense; (2) requiring employers to provide choices to their employees from among at least three insurance options, with incentives for employees to select less

expensive plans; and (3) copayments and deductibles, particularly for routine or nonemergency services, to discourage inappropriate or excessive use (Enthoven, 1980).

The simplicity of this approach is unnerving for many health policy pundits. Familiar arguments about equity, access, and the dangers of fraud and abuse are exhumed and advanced to illustrate the difficulty, if not outright impossibility, of reducing regulation by relying on the market (Ginsberg, 1980; Aday, Anderson, and Fleming, 1980:231–248; Fein, 1980:376–381). Ironically, these very same arguments are made by the professional associations, who for years argued against government regulation on the grounds that professionals are independent entrepreneurs. Uncertainty about how the market would work with minimal regulation, if it were allowed to do so, is cause enough for most observers to opt for the *status quo.* For others, such as the professional associations, unfettered self-regulation conducted by the professions is the preferred alternative to increased reliance on the market.

The often unstated tenet underlying a truly competitive model for the health system is that most decisions about supply and demand should be made privately. This assumption clearly swims against the contemporary tide of government regulation in this sector. Over the past fifteen years, government's share of health expenditures has nearly doubled, increasing from 21 percent in 1965 to over 40 percent today (Department of Health and Human Services, 1980:283). Federal legislation, starting with Medicare in 1965, has increasingly interposed government decision makers or fiscal intermediaries between the providers and users of health services. Slowing this trend, perhaps even reversing it a little, is probably overdue.

It is important to note that congressional concern about accountability was the impetus behind the volumes of the Code of Federal Regulations devoted to the health industry. Since federal dollars were going to flow to health care providers, Congress insisted on a regulatory structure to assure proper disbursement of those funds. Unfortunately, regulatory structures, once in place, have a tendency to grow through the process of bureaucratic self-generation. Also, during periodic reauthorization of health programs, Congress usually adds responsibilities to the regulatory mandate. Given that most government programs were initially premised on the notion of market failure, it is no wonder that federal health initiatives seldom have been geared

toward encouraging competition. For quite some time, competition has been seen by Congress and regulators alike as part of the problem rather than as a potential solution.

However, the regulatory approach has not yielded stellar results. Costs continue to go up faster than inflation no matter what the Health Care Financing Administration does to tighten down on Medicare expenditures. For example, reviews of the professional standards review organization (PSRO) program have revealed that it actually costs more to administer than it saves (Congressional Budget Office, 1979; Department of Health, Education, and Welfare, 1979). Over a billion dollars has been spent on health planning since 1974, and we still have enormous excess hospital capacity in most metropolitan areas. In fact, studies of capital expenditure regulation, through certificate-of-need (CON) programs, indicate that these controls have failed to stem excessive investment by hospitals (Salkever and Bice, 1979; Lewin and Associates, 1975). The transaction costs to the system of many of these regulatory programs go far beyond mere budgetary costs: the amount spent by hospitals in legal fees to challenge CON determinations must be staggering. Is there any way out of this costly spiral?

Enhanced private decision-making and diversity may be just what this industry needs, as long as the decision-making does not become dominated by provider groups. Avoiding organized provider control is the key to success for a competitive model. The real danger in moving toward a competitive approach is that effective legal procedures for assuring fair methods of competition may not be retained. In the rush to eliminate needless or overly burdensome regulation, it is possible that the means for assuring future competition will be thrown out as well.

One of the most effective, but least intrusive, methods for assuring fair competition is enforcement of the antitrust laws. But, the experience of the Federal Trade Commission (FTC) during the 1980 Senate debate on its authorizing legislation illustrates just how tenuous the continued existence of this enforcement tool really is. A floor amendment, offered by Senator James McClure, would have terminated the FTC's authority to investigate and remedy alleged antitrust violations if they were perpetrated by members of a state-regulated profession. The McClure Amendment was defeated, but only by two votes.

The Evolution of Antitrust Doctrine

Application of the antitrust laws to the professions is in its infancy. The 1975 Supreme Court decision in *Goldfarb* v. *Virginia State Bar* was the watershed for cases challenging anticompetitive professional activity.[1] However, *Goldfarb* and its progeny have raised more questions than they answer concerning special characteristics of the professions that may alter traditional antitrust doctrine. For example, the Court said that it is "unrealistic" to view professional practice as interchangeable with other business activities in a footnote to *Goldfarb.* The Court further intimated that the public service aspect and other special features of professions may require different treatment under the Sherman Act for professional practices that would be violations in other contexts.[2] The Court narrowed this a bit three years later, in *National Society of Professional Engineers* v. *United States*, by saying that the "nature of competition" in professional services may vary from other business services and that this should be taken into account if the courts are asked to balance the pro- and anticompetitive effects of a particular restraint.[3] Still, the Court in *Engineers* did not provide much guidance on the factors to be considered in assessing how competition among professionals differs from other businesses. The three factors it did enumerate were: the facts peculiar to the business (or profession); the history of the restraint; and the reasons why restraints on competition were imposed. The Court was quite clear that it is not up to the courts to decide whether or not competition is in the public interest: unless there are statutory exemptions to the contrary, Congress has said that competition is the modus operandi for our economic system.[4]

Antitrust analysis can proceed along two complementary tracks. The first track applies to agreements which, by their nature and effect, are so clearly anticompetitive that they are illegal per se. Price-fixing agreements and economic boycotts are examples of per se violations.

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[1] 421 U.S. 773 (1975). *Goldfarb* laid to rest the so-called learned professions exemption from the antitrust laws by holding that professionals are engaged in commerce and are subject to the provisions of Section 1 of the Sherman Act.

[2] 421 U.S. at 788 n. 17.

[3] 435 U.S. 680 (1978).

[4] 435 U.S. at 692.

The second track consists of agreements or behaviors whose competitive effects must be evaluated to see if they do more to foster than to impede competition. This latter analysis is termed *rule of reason* because it involves the courts in balancing procompetitive and anticompetitive effects.

Antitrust attorneys who work for the government or represent plaintiffs prefer per se cases to those based on the rule of reason. It is much easier to litigate per se cases because the government, or the plaintiff in a private suit, is not required to submit detailed information on the economic impact of the challenged restraint. If the acts occurred as alleged, that alone is enough to establish a violation under per se analysis.

Language in *Goldfarb* and *Professional Engineers* calls into question whether long-established per se rules will control in matters involving professionals. Doubts about whether health should be treated differently were heightened by the recent decision of the United States Court of Appeals for the Ninth Circuit in *Arizona* v. *Maricopa County Medical Society*.[5] There, the court concluded that marketing restraints, in the form of maximum fee schedules imposed on participating physicians by foundations for medical care, might survive a rule of reason analysis even though similar restraints in ordinary business would not. Thus, the majority refused to brand these kinds of restrictions as per se illegal.

The *Maricopa* decision has evoked considerable interest among state attorneys general and the federal antitrust bar. A petition for review, the outcome of which may have a profound effect on the evolution of antitrust enforcement in this industry, is pending with the Supreme Court. If the *Maricopa* decision is sustained, the contention that professional activities should be treated differently from their business counterparts will be bolstered. At the same time, fears about rigid application of the antitrust laws to the health care context will be allayed, since rule of reason analysis would take into account peculiar characteristics of this market in assessing the competitive effects of the restraints being reviewed.

The point is, antitrust doctrine is not wooden. Like many areas of the law, it is still evolving. And, in this new area of application, we will have to wait and see how the lower courts flesh out the

[5] [1980] *Trade Reg. Rep.* (CCH) ¶78,153.

skeletal acknowledgement by the Supreme Court that professional practices do differ from normal business practices.

Assuring the Existence of Competitive Conditions in the Market

The difference between a competitive health care market and the current market is *not* that the former would be unregulated and the latter is heavily regulated. Any competitive market requires monitoring and intervention from time to time to assure that competition is open and fair. Given the potential for the exercise of monopoly power by physicians, dentists, hospitals, or other providers, some means for policing health care markets must be an integral part of reforms designed to enhance competition. This market policing function is the traditional role of antitrust enforcement.

Activities that elicit antitrust scrutiny include: barriers to entry in particular markets, territorial or market restrictions, economic boycotts, price fixing, tying the purchase of one good or service to the purchase of another, and restricting the flow of truthful information between buyers and sellers. All of these activities in one form or another take place in the health care industry. Some are protected from antitrust challenge because of state or federal legislation (through state action[6] or implied repeal[7] doctrines) or because they are constitutionally protected by the First Amendment.[8] However, most are not protected, and rightly so.

Antitrust principles are derived from very basic assumptions about our economy. One assumption is that competition promotes efficiency and innovation. The rivalry among competing firms, or actors, tends to keep costs down and maintain high quality (or, quality that is at least higher than it would be if a monopoly prevailed). Also, resources tend to flow out of areas of declining demand into newer areas, thereby

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[6] *California Retail Liquor Dealers Association* v. *Midcal Aluminum*, 100 S. Ct. 937 (1980); Parker v. Brown, 317 U.S. 341 (1943).

[7] *Gordon* v. *New York Stock Exchange*, 422 U.S. 659 (1975); *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963).

[8] *Eastern Railroad Presidents Conference* v. *Noerr Motor Freight*, 365 U.S. 127 (1961); *United Mine Workers* v. *Pennington*, 381 U.S. 657 (1965).

encouraging innovation and change. A second assumption is that competitive markets are stable markets because they adjust continuously to market conditions. Third, antitrust assumes that competition encourages diversity through decentralizing power. This means that, as more choices are made available to consumers through the operation of the market, the likelihood of any one producer gaining control is diminished. These assumptions, in turn, are based on strongly held social values about individual initiative, the dangers of big government and big business, and individual freedom to pursue a chosen line of endeavor.

A market, albeit imperfect, already exists for health services. But, until quite recently, information about price and quality was extremely difficult to obtain. Ethical restrictions on professional advertising, which went far beyond establishing guidelines for assuring that the ads were truthful, effectively reduced information dissemination through this channel to a mere trickle. At best, physicians who advertised were looked down on by their peers; at worst, they were penalized by losing referrals, hospital privileges, membership in their local or state medical societies, or medical society controlled malpractice insurance. Knowledge of these sanctions chilled any interest in advertising for most physicians and dentists.

The 1977 decision of the Supreme Court in *Bates* v. *Arizona State Bar*,[9] bolstered by the FTC's order against the American Medical Association (AMA),[10] turned this situation around. In *Bates*, the Court held that commercial speech does enjoy some First Amendment protection, particularly when the object of that speech is to convey information about prices. The Court held that advertising the prices of routine legal services is not inherently misleading and that a total ban, even though imposed here by the Supreme Court of Arizona, violated constitutional guarantees of free speech. In the *AMA* case, the FTC found the AMA ban on advertising and solicitation to be a violation of Section 5 of the FTC Act on the grounds that it was an unfair method of competition. However, the FTC order allows the AMA to adopt and enforce reasonable ethical guidelines concerning false or deceptive advertising within the meaning of those terms in the FTC Act. While the primary effect of these two decisions is to

[9] 433 U.S. 350 (1977).
[10] American Medical Association, 94 FTC 701 (1980).

assure a competitive environment, they also demonstrate that, in order for competition to be fair, purchasers must be able to obtain truthful price information through advertising by professionals.

As Havighurst notes, the boycott is the most potent weapon wielded by professional associations (Havighurst, 1980:110). Economic boycotts, unless specifically exempt from the antitrust laws (such as those organized by labor unions), are per se antitrust violations. Health care providers have used illegal boycotts to force other providers to abandon the formation of health maintenance organizations (HMO)[11] and to stymie rigorous cost-control programs implemented by insurers.[12] The boycott is an effective tool for eliminating competitive forces in the health context, since negative sanctions by the medical society may have severe economic consequences in many communities.

Group boycotts by commercial firms are a common form of anticompetitive restraint on trade, and they are not saved from antitrust scrutiny by claims that they were reasonable under the specific circumstances or that they failed to actually fix prices.[13] Applying traditional antitrust law, the FTC has investigated a number of physicians' and dentists' groups which allegedly engaged in illegal boycotts. These cases fall into two general categories: boycotts aimed at new forms of practice[14] and boycotts organized against insurers.[15]

It is hard to imagine how health care providers, let alone consumers, would be protected from the adverse consequences of economic boycotts if the antitrust laws were not applied to the professions. The virtue of antitrust is that it comes into play only in instances where competitors go beyond the bounds of acceptable behavior in the marketplace. These limits, while often defined by statute, really reflect societal norms about behaviors that are constructively competitive and those that are not. Until quite recently, professional groups have defined and enforced these norms, often to their own benefit. Since

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[11] *American Medical Association* v. *United States*. 317 U.S. 519 (1943).
[12] Indiana Federation of Dentists, FTC Docket No. 9118 (March 25, 1980) (initial decision).
[13] *Klors, Inc.* v. *Broadway Hale Stores*, 359 U.S. 207 (1959).
[14] Forbes Health System Medical Staff, FTC Docket No. C–2994, 94 FTC 1042 (1979); American Society of Anesthesiologists, 93 FTC 101 (1979); Hope et. al., FTC Docket No. 9144, 46 Fed. Reg. 13235–13237 (1981) (consent order).
[15] Indiana Dental Association, FTC Docket No. 9093, 94 FTC 403 (1979).

Goldfarb and *Professional Engineers*, this arrangement is no longer possible.

In a competitive market unpoliced by antitrust, anticompetitive combinations and conspiracies eventually would be formed. The resulting monopolistic or oligopolistic combinations would, in turn, penalize and attempt to stifle their weaker competitors. One of the paradoxes of competition is that the general rules of the game have to be established and enforced in order to assure that all competitors will have the opportunity to compete. The fact that some fail or substantially modify their mode of operation is one of the necessary consequences of competition. However, in a competitive market, failure should be a function of performance rather than the result of having been driven out by economic or political bullying.

Is Self-Regulation a Viable Alternative to Antitrust?

The primary argument against antitrust enforcement directed at professional activity is that professional associations have long been entrusted with the responsibility of policing the market and this form of self-regulation produces substantial social benefits. This assertion is based on the belief that professions are semiautonomous groups with their own norms and standards and that these are best enforced privately. While the motivation for making this assertion may be well meaning, and not fueled by anticompetitive animus, the potential for abuse is still very high.

Self-regulation, on its face, has tremendous intrinsic appeal. First, it avoids large expenditures for public servants to monitor and attempt to influence professional practices through regulation. Second, it avoids having to define, by statute or regulation, what constitutes good professional practice by delegating this responsibility to the profession itself—arguably the best group for making difficult judgments about professional competence. A related benefit is that this delegation allows for adaptation of professional standards to fit changing circumstances. Third, it encourages the profession to take responsibility for upgrading the overall performance of the group by building on professional pride.

Fourth, it assures that decision-making will be primarily at the state and local level and thereby be attuned to local or regional differences.

Professional self-regulation which develops seals of approval, such as specialty certification, tends to promote competition. As in other markets, this information about the qualities or characteristics of the providers is helpful to consumers. While specialty certification does not guarantee that the provider will in fact deliver high-quality care, it does show that the individual has completed a certain amount of training and has passed muster before a panel of his peers. Unlike licensure, certification does not limit entry since any physician can unilaterally limit his practice to an area of medicine without becoming certified in that area.

On the whole, professional self-regulation performs a number of vital functions from which society benefits. But the instances where it has been used to resist innovation (usually by penalizing innovators), fix prices, freeze out other qualified practitioners, and establish unnecessary restrictions on the commercial aspects of professional practice are too numerous for society to relinquish its authority to monitor these activities and to intervene. Economic self-interest is a sufficiently powerful motivation that we have to expect abuses of the powers we have delegated to the professions. Given the inherent conflict between social responsibility and economic self-interest, it is unrealistic to expect that professional associations can be delegated total control over market entry or setting the rules governing the commercial aspects of professional practice. The combination of limited public intervention, largely through antitrust enforcement, and considerable autonomy for the professions to regulate themselves would seem preferable (from the perspective of the professions) to the alternative of more intrusive command-and-control regulation imposed by government. Antitrust enforcement does not conflict with *legitimate* professional self-regulation (Grad, 1978:486).

Conclusions

The rub, of course, is that the medical and dental professions are quite comfortable with the *status quo*. Sixteen years ago organized medicine fought the enactment of socialized medicine by opposing Medicare. Today few physicians would support dismantling the pro-

gram. Why? It's not that they have changed their views on socialized medicine. Rather, physicians have benefited from public programs, like Medicare, because they have virtually eliminated the problem of bad debts. Similarly, PSROs are now accepted by most physicians, even though organized medicine initially opposed any federal scrutiny of medical practice. The long and the short of it is simply this: professionals don't dislike regulation; in fact, they reap substantial economic rewards from regulation that they control and government programs that pay their bills. Paul Starr may have been right when he said that a free market could be worse for a physician's economic well-being than government regulation (Starr, 1980:170).

Policy makers in the Reagan administration and on Capitol Hill will be under tremendous pressure not to harm the economic interests of physicians and dentists. But, at the same time, they will be hard put to perpetuate the *status quo*: the political trade-offs of the federal budget, inflation, and the changing composition of the nation's population will necessitate some changes. If the direction in health policy is toward greater reliance on market forces to keep prices down and assure better utilization of essential services, then it is important for policy makers to recognize the tendency toward monopoly in this industry. Furthermore, it is imperative that law enforcement techniques are available and can be employed to eliminate illegal anticompetitive activities in their incipiency. The antitrust laws can perform this essential function quite nicely.

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