Antitrust Concerns About Evolving Vertical Relationships in Health Care

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The greatest challenges faced by any organization are those generated by a dynamic environment. Health-care organizations have faced, and will continue to face, significant demands imposed by changes in the practice of medicine, technology, markets, and government regulation. Provider responses to these environmental changes range from denial and opposition to the active pursuit of strategies of modification and evolution. Mergers, alliances, and other strategic relationships are being used to gain stronger market presence and both to meet and resist changing market conditions. Because many of these relationships have potential competitive impacts, the level of antitrust surveillance of health-care providers has correspondingly increased. This antitrust surveillance is a source of concern among health-care providers.

Physician networks, preferred provider organizations, multistate hospital chains, and physician joint ventures are examples of horizontal combinations developing in health care. Providers at different levels in their health-care delivery system are also closely examining and modifying the nature of their vertical relationships with one another. In a 1996 speech before the Health Care Antitrust Forum, FTC Commissioner Varney noted that competition in health care is being transformed by vertical integration. That transformation continues today. Competition has shifted from competition between individual hospitals or small groups of hospitals to competition between integrated networks; from competition between independent providers to competition between group practices and integrated HMOs; from competition between clinics and stand alone outpatient facilities to competition between captured insurance subsidiaries of health-care networks.

The increasingly complex organizational relationships in the health-care industry are creating new management, marketing, financial, and legal challenges. In 1993, the Federal Trade Commission (FTC) and Department of Justice (DOJ) issued antitrust guidelines for the health-care industry (US-DOJ/FTC, 1993). These guidelines have been updated twice (USDOJ/FTC, 1994, 1996), each time providing clarification of how authorities are applying the antitrust rules within the health-care industry. Initially the guidelines illuminated concerns over horizontal combinations in the health-care industry. Each revision of the guidelines has provided slightly more guidance for health-care providers actively modifying their structural relationships, but providers envisioning innovative arrangements and vertical combinations still have little guidance from the DOJ and FTC.

This paper attempts to provide a simplified framework within which the antitrust concerns with vertical relationships in health care can be understood. As the basis for this framework, we present the concepts of technical efficiency and consumer surplus and link these concepts to antitrust enforcement. We then illustrate antitrust concerns with recent cases challenged by the Federal Trade Commission and the Department of Justice.

Exchange Relationships and Two Measures of Efficiency

Economic activity typically involves a complex set of vertical and horizontal relationships. A relationship is said to be “vertical” if it links entities involved in different functions during the production or delivery of a good or service. Physician-to-hospital and physician-to-pharmacist affiliations are examples of vertical relationships. In contrast, a relationship is “horizontal” if it is between two entities that perform essentially the same function. Associations linking physicians of the same specialty or a group of hospitals are examples of horizontal relationships.
Vertical as well as horizontal relationships can be defined along a number of dimensions: transitory-to-durable, independent-to-dependent, costless-to-costly. The variety of vertical relationships observed in the market reflects the differential advantages of firms and their strategic objectives. Firms (which can be viewed as a collection of internalized, durable relationships) at the same horizontal level may operate with very different degrees of vertical integration. For example, one outpatient clinic may have in-house laboratory services; whereas, another may contract with an independent laboratory for these services. One explanation for observed differences in the vertical integration of firms is the comparative costs of market transactions (including search time, information, monitoring/quality assurance, and uncertainty costs) versus the costs of integrating the relationship. For example, a physician might choose to sign a 6-month contract with a management company for receptionist services or alternatively might choose to hire a receptionist as a permanent employee. Decisions such as these have an impact on the technical efficiency or cost competitiveness of the firm.

In an ideal world where each market transaction is based on its competitive merits, there is pressure for each firm to achieve the vertical structure that minimizes costs. Within that structure, price is driven down to a level that only covers the costs of production. This price provides just enough return to keep the existing firms in the market and maximizes the consumer surplus (consumer's sense of a good deal) in that market. However, in a dynamic world, the “optimal” vertical structure that minimizes costs is continually changing because of changes in technology, market, and transaction costs. Physician–hospital organizations (PHOs), integrated health maintenance organizations (HMOs), and other emerging vertical alliances are motivated, in part by competitive pressures, to realize greater technical efficiencies and deliver greater consumer surplus.

The concepts of technical efficiency and consumer surplus play a key role in antitrust enforcement. Technical efficiency, or the cost of production, is determined in part by the extent and nature of the vertical relationships internalized by the firm. Consumer surplus, or the benefits that accrue to the buyer from a price below his or her maximum willingness to pay, is dependent upon market price. In an open market economy, actual as well as potential competition are held to maximize both technical efficiency and consumer surplus.

**Antitrust Goals and Enforcement Considerations**

Sullivan (1977) argues that antitrust enforcement is based on a populist tradition. In his view, dread of artificially high prices, preferences for decentralized economic power (small versus large organizations), and opportunities to exercise entrepreneurial impulses drive antitrust enforcement. This view is largely consistent with the premise that the protection of consumer surplus is the primary goal of antitrust enforcement. Consumer surplus is the greatest when consumers can exercise choice among a variety of service and price options according to their own needs. Thus, the primary effort of antitrust enforcement is to keep markets open to new and existing competition so that competitive forces stimulate the development of products and services desired by consumers. In the health-care sector, the rationale for many of the new organizational structures and complex relationships among providers (both horizontal and vertical) has been the development of new health-care services and delivery systems that attempt to meet the preferences and needs of consumers.

Horizontal agreements among competitors that concentrate enough market power to thwart competition and artificially raise market prices have long been challenged by antitrust authorities. Because competition drives down costs as well as prices, antitrust authorities are largely sympathetic to cost-driven changes in market power. This, however, is subject to an important qualification. Sullivan (1977) notes that antitrust enforcement operates from questions that are sufficiently factually determinant for judicial inquiry. Market shares, concentration ratios, and other measures of market power satisfy this criterion. Readily available empirical measures of market power are implicit in several of the safety zones enunciated in the USDOJ/FTC antitrust guidelines for health care (USDOJ/FTC 1994, 1996). Measures of cost savings and other technical efficiencies that would be helpful in evaluating the impact of vertical relationships are much less available, because the necessary information is difficult to obtain and expensive to verify. The uncertainty and ambiguity of the impacts on competition from strengthening the vertical ties between two or more firms means that such vertical relationships are likely to be judged by their impact on the actual or potential market power of either entity. If the vertical relationship can be used as a vehicle to develop, maintain, or extend horizontal concentrations of power, it is likely to invite antitrust challenge.

Despite their reliance on available empirical measures of market power, antitrust authorities understand the wisdom of not applying generalities too strictly. Practices that qualify as per se violations of antitrust laws are vastly outnumbered by those that are evaluated under a rule of reason analysis. Under a rule of reason analysis, business practices are evaluated case by case to determine whether, on balance, the potential benefits outweigh the potential costs. Such analyses can help identify those factors driving the dynamics of an industry.

In the health-care industry, antitrust authorities are sympathetic to combinations of providers structured to deliver on promised claims of cost savings or the delivery of new products/services that directly benefit consumers. For example, physician panels are often formed to reduce transactions costs and increase the cost effectiveness of delivery. Antitrust officials look favorably on provider panels that limit the number of participating physicians and that require financial integration and risk sharing (Fuller and Scammon, 1996).
Concerns Arising From Vertical Relationships in Health Care

The rapidly changing structure of vertical exchange relationships, and most specifically, the rapid rise of integrated entities in health-care delivery, causes antitrust concern. Antitrust authorities acknowledge that these integrated entities are expected to realize lower costs (technical efficiency) through economies of scope, shared services, coordination economies, and improved organizational incentives for cost-effective care. They also express concern over the competitive harm these new structures may cause (Varney, 1995). Competitive harms of particular concern are exclusion, facilitation of collusion, and threats to entry. We turn to these next and illustrate each with current examples. These examples were selected both because they represent practices common in the health-care industry and because they illustrate the fact that anticompetitive practices are likely to have multiple detrimental impacts on competition. It is important to note, however, that within the health-care industry specifically, there are a very limited number of litigated antitrust cases, because most complaints have been settled with consent agreements. Readers interested in tracking the evolving thinking of the antitrust authorities about the application of the antitrust laws to health care should consult the FTC’s advisory opinions and the DOJ’s business review letters issued in response to specific requests for advice from firms proposing new relationships, both horizontal and vertical (Leibenluft, 1997).

Exclusion

Possibilities of exclusion or foreclosure of a competitor from the market occur when an entity develops closer and more exclusive vertical relationships with either an upstream or downstream entity. Competitive harm can develop at either level of the vertical relationship. Exclusion generally requires one of the participants in a vertical relationship to have a market share sufficient to create less favorable access upstream or downstream for competitors. Exclusion is achieved by offering less preferable terms or refusing to provide services or supplies to those outside the relationship. Two recent cases, one pursued by the DOJ and one by the FTC illustrate the possibility of exclusion.

Louisiana Women’s Hospital, specializing in obstetrical care, has nearly every obstetrician and gynecologist in Baton Rouge on its staff. It delivers about 94% of privately insured newborns in Baton Rouge. In 1993, Women’s Hospital formed an alliance with Women’s Physician Health Organization, of which almost every obstetrician and gynecologist serving privately insured patients in Baton Rouge was a member. The alliance appointed a consultant and a committee of nonphysicians that established a minimum fee schedule for physician services and negotiated on behalf of the doctors and the hospital with managed care plans. The resulting fees were substantially higher than the fees doctors had received when they contracted individually with the largest managed care plan in Baton Rouge.

The Department of Justice subsequently filed a complaint alleging the alliance sought to prevent the development of competition among area hospitals for inpatient obstetrical care. Using the incentive of higher fees to deter obstetricians and gynecologists from sending patients to competing facilities, Women’s hospital sought to use the alliance to maintain its monopoly position. Furthermore, the complaint alleges that Women’s hospital sought to convince General Health Inc. to agree not to provide inpatient obstetrical care at its health center. The complaint was settled by a consent decree in 1996 (USDOJ, April 23, 1996).

In another recent case (FTC, October 23, 1997), Montana Associated Physicians, Inc. (MAPI) was formed to represent independent physicians in Billings (those not affiliated with a large, multispecialty clinic). Its members included approximately 115 physicians in 36 independent practices in Billings, just over 80% of all independent physicians. According to an FTC complaint, MAPI orchestrated boycotts and agreements among its physician members to fix the prices they would accept from third-party payers at levels higher than their usual and customary fees.

Billings Physician Hospital Alliance, Inc. (BPHA), a physician–hospital organization (PHO), was formed to negotiate on behalf of physicians with third-party payers. Its members were Saint Vincent Hospital and Health Center and 126 physicians on the hospital’s staff. The physician members of BPHA are primarily MAPI members. MAPI was designated as the agent for almost all BPHA physicians. MAPI had the authority to accept or reject all contracts negotiated by BPHA. BPHA did not enter into any contract for physician services until nearly 2 years after its creation. The FTC alleged that the actions of BPHA and MAPI effectively blocked the entry of a
Preferred Provider Organization (PPO) seeking to contract for physician services in the Billings market. As a result, consumers had fewer health-care choices and had to pay higher prices.

Physicians’ groups may claim transaction cost efficiencies in negotiation with third-party payers and hospitals as one rationale for the necessity of collective price agreements. Moreover, the possibility of increased consumer surplus as the result of an HMO/PPO or a hospital offering a new product/service to the market is attractive. However, these two cases illustrate the possibility of exclusion of competitors (actual and potential) as the result of the exercise of horizontal market power at the physician level. This is just the sort of harm to competition that the antitrust authorities seek to prevent.

Facilitation of Collusion
A goal of most firms is to increase profits. Individual firms may increase their profits by increasing their market power following strategies designed to increase market share through internal growth, merger, or acquisition. An alternative approach to increase industry profits is for competitors to agree, explicitly or tacitly, not to compete. Because of the legal sanctions for explicit collusion, tacit collusion provides the best opportunity to restrict competition among horizontal competitors. Unfortunately for those who would collude, the individuals who are party to collusive efforts often have a profit incentive to cheat on the agreement. Thus, it becomes essential to the success of tacit collusive efforts that some way be found to signal intentions and to monitor the price and output activity of others. The acquisition of professionally managed prescription drug benefit programs (PBMs) by several large pharmaceutical manufacturers offers an example of a way in which integrated companies could monitor the competitive practices of others. In this example, the competitive harm appears at both the level of the benefits plans and the pharmaceutical manufacturers.

Through the 1980s, PBMs became a significant element of managed health care. PBMs typically select pharmacists, drug manufacturers, and suppliers, administer point-of-sale claims processing systems, negotiate quantity discounts with pharmaceutical manufacturers and pharmacists, administer plan record keeping and payment systems, and maintain quality control. One way that they attempt to control costs is by establishing lists, called formularies, of approved drugs. Formularies can be open or closed. With closed formularies, insured individuals are reimbursed only for drugs that are included in the formulary. Thus, there is a financial incentive for physicians to prescribe and pharmacists to dispense drugs that have been pre-approved by the PBM. In contrast, with open formularies, insured individuals will receive some reimbursement for drugs whether they are included on the formulary or not. Thus, presumably, no manufacturer’s drugs are excluded from consideration by those prescribing and dispensing drugs because of financial incentives. In designating drugs to be included in a formulary, the PBMs negotiate discounts from pharmaceutical manufacturers in return for placing the manufacturer’s drug on the PBMs formulary.

After several acquisitions of PBM’s by the competing pharmaceutical manufacturers Merck & Co. and SmithKline Beecham PLC, Eli Lilly proposed to acquire PCS Health Systems, the largest PBM in the country. Alleging the combination would facilitate collusion in pharmaceutical manufacturing and PBM markets and potentially foreclose markets, the FTC challenged the acquisition. Specifically, the complaint alleged that the acquisition could facilitate collusion through reciprocal dealing, coordinated interaction, and interdependent conduct among Lilly and other vertically integrated pharmaceutical companies.

A settlement was negotiated that requires Lilly to offer both an open and a closed formulary. Lilly must also erect and maintain a “firewall,” or a system that precludes communications between Lilly and PCS concerning bids, proposals, prices, and other information related to other drug manufacturers’ products (Varney, 1996). These provisions are intended to ensure that no pharmaceutical manufacturer is disadvantaged because of preferential treatment given to the drugs produced by Lilly in designing formularies for PCS’s insured.

PBMs are an example of an innovative vertical relationship created ostensibly to enhance cost effectiveness, but that carries the possibility of competitive harms. In addition to the facilitation of collusion, critics worry that manufacturers will utilize captive PBMs to foreclose competitors’ products from the market. Recently, groups of pharmacies have begun to form joint venture PBMs. In 1996, the National Association of Drug Chain Stores petitioned the FTC to impose additional changes on the combinations of Eli Lilly and PCS, Merck & Co. and Medco Containment Services, and SmithKline Beecham PLC’s purchase of Diversified Pharmaceutical Services. The petitioner alleged price manipulation (sweetheart deals) by the integrated entities leading to increased market share for their prescription drugs achieved through exclusionary pricing practices (Gruley and Burton, 1996).

Barriers to Entry
Closer and stronger vertical relationships between health-care providers raise competitive concerns whenever they decrease the likelihood of entry by a competitor. For barriers to entry to exist, markets must first be characterized by a sufficient degree of integration that potential competitors must enter both markets simultaneously. Second, the necessity of entering several markets simultaneously must be shown to be a significant barrier to entry. A higher cost of capital because of increased risk from such factors as inexperience at one level, sunk costs caused by brand (or provider) loyalty, or inability to obtain sources of supply or outlets at competitive conditions may be evidence of entry barriers. Third, if the minimum efficient scale of operation differs significantly at the two market levels, an entry barrier may be inferred. If vertical relation-
ships make “two level” entry necessary, this essentially raises the costs for potential rivals. Although the vertical integration may create procompetitive benefits in terms of increased consumer surplus, it may harm individual competitors. Balancing the benefits and the costs can be difficult.

The use of most-favored-nation (MFN) clauses by dominant third-party payors, a practice that has been closely scrutinized by the antitrust authorities, provides a case to examine the possibility of both competitive benefits and harm. In a 1989 case, the First Circuit Court of Appeals upheld the use of an MFN by Blue Cross & Blue Shield of Rhode Island (Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island, 1989). The DOJ, however, has challenged such agreements in four recent cases.

An MFN clause requires each provider to charge a fee no higher than the lowest fee the provider accepts from any other HMO. Competitive injury can occur at the level of the third-party payer. That is, when coupled with significant market share, MFNs reduce the likelihood that significant numbers of physicians will deeply discount to a potential entrant HMO.

Blue Cross, long the dominant health insurer in Rhode Island, faced entry by for-profit HMO Ocean State in 1984. Ocean state instituted cost containment and financial integration through a 20% withhold of fees, to be returned to physicians if it made a profit. By 1986, enrollment in Ocean State had grown to 70,000; some of that growth came at the expense of Blue Cross. In the same year, Blue Cross initiated a three-pronged attack, one prong of which was a policy called the “Prudent Buyer.” This was a policy of not paying a physician more for any service or procedure than that physician was accepting from any other health-care provider. After Ocean State failed to make a profit in 1985 and 1986, Blue Cross required each of its participating physicians to certify that he or she was not accepting lower fees from other providers than he or she was receiving from Blue Cross. If certification was not provided, Blue Cross reduced that physician’s fees by 20%. After implementation of the Prudent Buyer plan, 350 of Ocean State’s 1,200 physicians resigned. The First Circuit Court of Appeals found the Prudent Buyer policy was simply legitimate competition (even though by a monopolist).

The DOJ has successfully challenged MFNs in four cases. One case involved a 1994 complaint against Delta Dental Plan of Arizona (US v. Dental Plan of Arizona, Inc., 1994a). With 85% of Arizona dentists affiliated, the DOJ alleged that the MFN practice deterred entry from competing dental insurance plans and eliminated price discounting. The DOJ alleged that, because the majority of dentists’ income was derived from the Delta Dental Plan, there was little likelihood dentists would discount to entran dental insurance programs. This effectively blocked the entry of competing dental insurance plans.

Most recently, the DOJ sued Delta Dental of Rhode Island, Rhode Island’s largest dental care insurer, alleging that Delta Dental’s use of MFNs had the effect of preventing dentists from cutting fees, making it harder for other dental insurance plans to negotiate a favorable fee schedule from local dentists, and thus deprived consumers of lower-cost dental insurance (DOJ Press Release, 1997). This is the fourth case in which the DOJ has challenged MFNs (the other two cases are US vs. Oregon Dental Services, 1995 and US vs. Vision Service Plan, 1994b). In addition to creating barriers to entry to organizations seeking to negotiate lower fees from providers, MFNs have also been alleged to facilitate collusion among participating providers, thus leading to competitive harm at two levels of the vertical relationship.

Conclusion

Modifying and strengthening vertical relationships in the health-care industry holds the prospect of the same efficiencies and benefits realized in other industries. Health-care organizations may be able to improve their operations by ensuring a supply of patients, coordinating services and facilities, enhancing and controlling the quality of the service, and controlling the costs of supplies by modifying and strengthening vertical relationships. However, in so doing, they must be cognizant of the business and legal risks.

Antitrust scrutiny is a major concern in the health-care industry. Although the FTC and DOJ have issued guidelines for the health-care industry, these are more explicit about horizontal combinations and leave antitrust concerns over vertical relationships relatively unexplained. It is our position that antitrust concerns about vertical relationships arise primarily through their impact on the horizontal relationships between (potential) competitors. Thus, if one of the partners in an evolving vertical relationship has significant market power (share), and the vertical relationship can be used as a vehicle to maintain, protect, further or transfer that market power upstream or downstream, antitrust concerns may be raised. We have focused on three ways in which vertical relationships can have negative impacts on competition. Exclusion occurs when actual competitors face unfavorable conditions upstream or downstream (including artificial cost disadvantages). Barriers to entry can force a competitor to enter multiple levels of the market. Tacit collusion is also a concern, particularly when the horizontal competitors involved in the collusion have no shared financial interest (that is, they are not integrated).

The DOJ and FTC have indicated a willingness to allow vertical relationships that do not have the potential to foster any of these three results in the marketplace. Such relationships will be examined under a rule of reason analysis. Thus, they will be allowed if the potential benefits achievable through the relationship exceed the potential costs imposed by the relationship. It is vital that health-care organizations carefully articulate their rationale for forming vertical relationships and that they highlight the likely benefits with precision.

References


U.S. Department of Justice: Louisiana Woman’s Hospital and PMO Charged. DOJ press release, April 23, 1996.


