The vision of competition that is described in the 2004 report by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) on antitrust and competition in the health care field (hereafter, the “Report”) is one that is filled with examples of innovation and the ways in which physicians, hospitals, health insurers, pharmaceutical companies, and employers have changed and are changing the way health care services are provided and purchased. This innovation has been the centerpiece of competition in health care, and the FTC and DOJ should receive a great deal of credit for recognizing the variety of ways in which innovation must be accounted for in health care competition law and enforcement.

There is no question that sound health care antitrust policy must involve research and policies that promote competition without discouraging innovation. However, this is not easily accomplished, and to frame the issues, we begin with a discussion of the various ways in which innovation has helped to spur competition in health care markets. This is innovation defined at its broadest—it includes the advances in medical technology that created new types of health care providers such as ambulatory surgery centers and specialty hospitals, as well as the organizational and financial innovations that helped to create new types of health care insurance and financing arrangements. These are the sorts of innovation that changed the nature of competition in health care markets, and as a result, the analyses that must be applied when evaluating the competitive implications of proposed mergers and acquisitions and alleged anticompetitive conduct.

Moreover, the largely undisputed benefits of many of these innovations give rise to another important antitrust policy issue: how should we evaluate the competitive consequences of innovative solutions that are the result of a collaboration among competitors—such as a new medical service or an agreement among health care providers in a community to share clinical “best practices” or improve the allocation of health care resources? Although the FTC and DOJ seem willing to let the market “experiment” with innovations as long as they are undertaken unilaterally, the difficult antitrust policy question will involve solutions that entail the collective effort of a group of competitors. Because many innovations are expensive and difficult to organize and achieve, they may require pooling of financial and human capital by multiple parties, which could well include competitors. As a result, some experiments may be structurally possible only if there is participation by competitors.

The antitrust issue is particularly complex because when multiple competitors merge or form a partnership or joint venture, it may not be easy to isolate and evaluate the tradeoff between collaboration and competition, particularly in an ex post analysis. That is because some innovative solutions—especially those that are valuable to patients—may lead to higher prices. In these cases, it may be difficult to measure the degree to which the increase in prices resulted from legitimately more expensive and costly ventures or an improvement in the quality of care provided as opposed to anticompetitive conduct and reduced competition. These situations pose difficult questions in antitrust analysis, and we conclude with a discussion of the challenges ahead.

**INNOVATION AND THE CREATION OF NEW SOURCES OF COMPETITION**

Innovations—technological, financial, and organizational—have created new sources of competition in health care markets. Technological innovations in medicine include those that have provided us with new ways to cure formerly non-treatable diseases, and those that have given hospitals and physicians new alternatives to existing modes of treatment. Medical advancement of this kind, which can change the variety of treatment alternatives that are available for patients, is critical in an antitrust analysis because it can affect the definition of product and geographic markets. There also have been financial and organizational innovations, such as those that were developed in response to marketplace demands for cost-effective health care. These include the creation of health maintenance organizations (HMOs) and the multitude of health care financing options that have evolved from that basic idea (e.g., point-of-service health plans and, more recently,
Innovations in the financing of health care have dramatically changed the financial incentives faced by hospitals, physicians, and other health care providers.

Health Insurance

Innovations in the financing of health care have dramatically changed the financial incentives faced by hospitals, physicians, and other health care providers. These changes have had an effect on the way consumers choose hospitals and physicians, as well as the way providers are paid. Many of these changes have contributed to a reduction in the growth of health care costs.

Changes in the way physicians are reimbursed are among the most important developments, and the developments in this area illustrate how innovation has reduced health care costs and encouraged competition among providers, as well as competition among health insurers. Innovations in physician reimbursement methods—along with a variety of management techniques—have been particularly instrumental in reducing health care costs. For example, by using cost containment techniques such as utilization review and requiring physicians to obtain pre-authorization before a patient can be referred to a specialist, many managed care health plans have been able to control their physician costs. Further, through risk-sharing (e.g., capitation contracts) and other financial incentives (e.g., bonus payments based on the degree of compliance with treatment protocols and other clinical goals or financial targets), managed care health plans have done a great deal to encourage providers to practice more efficiently. “Pay for Performance” initiatives, which are strategies designed to align physicians' financial interests with measures of quality of care and/or clinical outcomes, were developed in the same spirit. These mechanisms are important because they give physicians an incentive to consider costs and outcomes when making decisions about the medical services and treatments to be given.

Health insurers also have promoted competition among physicians and hospitals through selective contracting and the creation of preferred physician and hospital networks. Because many patients choose their insurance carrier based on the breadth and depth of the insurer's provider network, insurers have strong incentives to identify physicians who could provide high quality, cost-effective care and to contract with them. Physicians also have incentives to sign such contracts, since they benefit from the high volume of patients these contracts tend to provide.

At the same time, insurers also have created new types of health plans that revolved around their different provider networks. For instance, on one end are plans that offer benefits coverage only if the enrollee seeks care from a preferred provider or a provider that is “in” the network (e.g., an HMO). On the other end are a multitude of plans that offer consumers a range of options regarding the degree to which benefits coverage is provided if the enrollee seeks care from an out-of-network provider. Moreover, companies have created provider networks that they “rent” to insurers, which has facilitated competition by helping many insurers enter and expand into new geographic areas. As a result, employers and consumers have a wide variety of choice when it comes to purchasing health benefits coverage.

Hospital Services

Technology has probably been the most important driver of innovation in the area of hospital services, as evidenced by the rise of single-specialty hospitals (SSHs) and ambulatory surgery centers (ASCs). SSHs and ASCs are new alternatives for patients, and as a result, new sources of competition for general acute care hospitals.

SSHs typically specialize in providing care for certain conditions, such as cardiac care and orthopedic surgery. Although specialty hospitals have existed for a long time (e.g., Children’s hospitals), the newer types of SSHs are different in that they are often partly owned by participating physicians. Because of their focused range of operation, SSHs may be able to use their resources more efficiently to...
serve the needs of certain types of patients. Also, SSHs may be more aggressively managed financially since participating physicians often have direct financial interests in the performance of their SSHs.

Advancement in medical techniques and technology also contributed to the development of ASCs, where surgery is performed on an outpatient basis. Examples of the kind of services offered at ASCs include cataract removal, arthroscopic knee surgery and hernia repair. Indeed, in many areas, the emergence of SSHs and ASCs has given patients an alternative to the general acute care hospital.

**Physician Services**

Historically, physicians have been solo practitioners. However, in the 1980s, they began to form network joint ventures, such as independent practice associations (IPAs) and physician hospital organizations (PHOs), to reduce their administrative costs and to contract more efficiently with health plans. These organizations may be financially integrated through contracts with health plans and/or clinically integrated through the provision of ambulatory care services. The rise of these organizations created new ways for physicians to negotiate with managed care organizations, thereby further changing the way in which reimbursement rates for physician services are determined, and ultimately how much consumers pay for physician services in premiums, copays and deductibles.

To further facilitate contracting with managed care plans, many physician networks have experimented with different types of messenger models, which are arrangements designed to facilitate contracting between physician networks and insurers. Messenger models have been under some antitrust scrutiny, but they can and have been helpful in providing individual physicians with the information they need to participate in managed care contracting.

**Pharmaceuticals**

Organizational innovations have altered the way prescription drugs are delivered to patients and have facilitated competition among pharmaceutical manufacturers. For example, many managed care plans have adopted formularies to manage their drug costs. The use of formularies has helped to promote more efficient drug choice by physicians and patients through guidance and financial incentives. Since there are often several similar products in the same therapeutic class, formularies have allowed managed care plans to encourage the use of products that they consider efficacious and cost effective. Managed care plans also began monitoring physicians’ prescribing patterns and identifying high prescribers of non-formulary or high-cost drugs. To encourage doctors and affiliated pharmacists to prescribe and dispense generics and lower priced brand name drugs, managed care plans introduced an array of incentive mechanisms. For example, those physicians who are considered as not conforming to prescription guidelines might be given information on cost-effective treatment alternatives and, in some cases, may be subject to financial penalties. Just as managed care plans have changed the way prices are determined for hospital and physician services, they, too, have altered the supply and demand relationships that govern pharmaceutical pricing and purchasing.

Pharmaceutical benefit management (PBM) companies are firms that administer pharmaceutical benefit plans for health plans or employers who do not have drug management expertise or who find it more appropriate to purchase the services externally. Many managed care plans also contract with PBMs to manage their prescription drug benefits. PBMs arose in the 1970s and grew rapidly in the 1980s and early 1990s due to increases in expenditures for prescription drugs, growing concerns regarding the rise in pharmaceutical and health care costs by employers and insurers, and the growth of managed health care generally. Although the traditional role of the PBM was that of a claims processor, the modern PBM controls pharmaceutical expenses by establishing networks of pharmacy providers, negotiating rebates and discounts with manufacturers, developing drug formularies and pre-authorization systems, managing drug utilization reviews (DUR), and providing prescription mail-order services.

DUR and mail-order services are particularly important developments that have changed the supply and demand relationships in pharmaceutical and pharmacy markets. For example, DUR has been quite important in helping PBMs evaluate the extent to which physicians and pharmacists are compliant with drug formularies and to inform physicians and pharmacists about cost differentials among various treatment alternatives. By increasing the amount of information available to pharmacists, physicians, and manufacturers, DUR has altered the competitive landscape of pharmaceutical markets. Mail-order services have also changed competition in retail pharmacy markets by providing patients with chronic conditions an alternative method to obtain prescription drugs.
CHALLENGES FOR HEALTH CARE ANTITRUST POLICY

As the FTC and DOJ describe in their report, competition has played an important role in health care markets. Indeed, the innovative process has changed the way health care is priced and paid for, and it is likely that such innovation will continue to change the supply and demand relationships and the nature of competition in a variety of health care markets. For the antitrust agencies, the mandate must be to enforce competition policy law in a way that encourages and protects such innovation and competition. The Report identifies a number of challenges for the antitrust agencies, but analyses of collaborative efforts among competitors top the list, particularly in an evolving marketplace where experimentation and innovation have long been part of the competitive dynamics.

Innovations Involving Collaboration Among Competitors

The Report seems to suggest that innovations involving unilateral conduct are generally acceptable under antitrust law. While sensible, some of the innovations described above are not the result of one firm’s creativity, but rather the product of collaboration among competitors. Collaborations have always been part of the innovative process in health care markets. Physician network joint ventures have enabled physicians to share clinical data and best practices. Hospitals have collaborated to share the provision of certain specialty services. Ventures among pharmaceutical and medical device firms have contributed to the invention of new drugs and medical devices. Indeed, some of the breakthrough drugs we benefit from today could not have been available to us without mergers and joint ventures among pharmaceutical companies.

Collaborations of this kind are particularly important when the innovation requires some large upfront investment of time and financial resources, such as that which may be needed to form a clinically integrated network of physicians or a program to collect and share data on best practices and clinical outcomes. Because many innovations are expensive and difficult to achieve unilaterally, firms may opt to enter into joint ventures to improve the likelihood of success by combining their financial and human resources as well as their intellectual properties. Moreover, some innovations may be possible only if several competitors decide to collaborate with each other. For example, drug discovery is a risky and costly business venture, which requires a substantial amount of capital and significant group effort by scientists. Similarly, some medical devices available to us today were made possible as a result of a merger or joint venture.

Collaboration among competitors has always been a controversial topic in antitrust generally, and the issues are just as complex in health care markets. In an evolving and dynamic marketplace, it may be difficult for collaborators (and their counsel) and the antitrust agencies to evaluate whether collaboration is or was needed to achieve the intended benefits. In other words, would the benefit have been obtained without the collaboration? Moreover, it may not be easy to determine whether joint pricing or joint negotiations were needed to achieve the intended benefits.

In health care markets, these questions will challenge our ability to identify and quantify the benefits that collaboration can yield. In many conventional goods markets, the creation of a “new product” may be more obvious, but in health care, the new product—if it is not a new service or the creation of a new patient care facility—may be more difficult to assess. Yet many joint ventures in health care markets do important things that ought to be considered equally valuable: a venture might create a better clinical or diagnostic approach (e.g., through the sharing of clinical data or best practices) or lead to the development of a patient outcomes database that may facilitate quality of care studies. In some cases, the benefit may not be a new product at all, but the provision of a service or attribute that patients and consumers care about, such as assuring quality of care or making sure patient records are seamlessly transferred from one physician to another.

Collaborative Experimentation in an Evolving and Dynamic Marketplace

The FTC and DOJ recognize that the ever-evolving health care marketplace is filled with experimentation as health plans, hospitals, physicians, and other providers compete to meet the demands of employers, consumers, and patients. Indeed, they specifically recommend that “[p]rivate payors, governments, and providers continue experiments to improve incentives for providers to lower costs and enhance quality and for consumers to seek lower prices and better quality.”

This policy suggestion has the right spirit, but the challenge for the antitrust agencies is to implement it in a way that does not discourage experimentation, particularly if collaboration is a necessary ingredient to developing an innovative solution. The principle analytical problem is that not all experiments or good ideas succeed. While this sounds obvious, the policy issue is that the antitrust agencies may be placed in a position to review the competitive implications of an experiment after-the-fact. There is nothing wrong with a review of historical conduct,
but we should be careful not to let an ex post perspective cloud our assessment of the ex ante view that motivated the experiment in the first place. For example, failure to create a new product does not mean the joint venture was anticompetitive. With joint ventures, it is as much about the organization itself and the process, as it is about outcomes. In other words, the intended efficiencies at the time the joint venture was created are critical to how we evaluate the joint venture. The agencies must be sensitive to the fact that their decisions regarding the competitive effects of experiments will have an impact on investment incentives in the future.

Moreover, assessing the competitive impact of transactions, contracting practices, business methods, or any other financial or organizational solutions may be further complicated if the solution was successful and therefore valuable to health plans, patients, and consumers. Consider, for example, a joint venture between two hospitals that led to the creation of a new cardiac program. As a result of this venture, the two hospitals were able to treat heart attack patients differently by offering them more types of surgical intervention (e.g., cardiac catheterization, which is a diagnostic procedure, after which the options might include cardiac bypass surgery, angioplasty, or angioplasty combined with the insertion of stents to hold open the artery). In other words, the venture succeeded in bringing a valuable new service to the community. However, suppose further that with its new cardiac capabilities, the venture became a “must have” provider for area health plans and therefore was able to negotiate higher reimbursement rates or to leverage this power to obtain other contractual concessions from payors. Is this an exercise of market power?

The competitive analysis is complex because while the joint venture may have been a procompetitive experiment that succeeded in offering a new service to the community, the service also may have given the new venture added bargaining power when negotiating contracts with health plans. The two possibilities are not mutually exclusive, which may make it difficult to determine how much of the price rise simply reflects the value of the new service to health plans and the community at large, and how much might be attributable to greater bargaining power. However, it is sometimes too easy to view all increases in price as being problematic, whether they are justified by higher costs or quality of care. Nevertheless, it is important to separate the competing effects because, in the end, much of the analysis will be about causality—if, in fact, prices rose, was it due to the improvement in quality of care, or was it due to something else, such as a reduction in competition?

**CONCLUSION**

In a dynamic and changing environment where the FTC and DOJ would like to foster experimentation, it is likely that competitive evaluations of these experiments will be ex post in nature. In an ex post analysis, it may be difficult to determine (a) what would have happened had there been no collaboration and (b) whether the outcome in a world without collaboration would have been more efficient or more beneficial compared to the outcome that actually occurred. Moreover, the analysis is complicated by the fact that many innovations could legitimately lead to higher prices or spending.

Given the importance of innovation in health care markets, we ought to be sure we do not chill the creativity. We should preserve competition, but not stifle the innovative creativity that has served health care markets so well. Innovations can create more choices for consumers, leading to higher quality and lower costs for health care services, which in turn encourage further competition. Innovations also can increase social welfare by allowing us to treat diseases for which there was no cure in the past and to manage them more cost effectively.

Clearly, experiments that seek to meet marketplace demands and innovations that are the product of collaboration, particularly among competitors, can raise competitive issues. While the competitive analysis of these issues is challenging, we should not forget the fundamental principles that matter, which is (a) whether the entity or venture at issue has market power and (b) whether the integrated venture (or its conduct) might have fostered collusion or created barriers to entry into the marketplace. In addition, if the experiment or the collaboration succeeded, we must balance the possible anticompetitive implications against the efficiencies and increase in welfare that new innovative solutions can offer in a dynamic health care market.

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An IPA is an entity that assists a group of physicians, usually in solo practice, with managed care contracts. The physicians in an IPA often provide care on a fee-for-service or capitated basis. A typical PHO is a joint venture between a hospital and its admitting physicians created for multiple purposes, including managed care contracting and administrative services.

As noted on p. 28 in the FTC/DOJ Report, “Improving Health Care: A Dose of Competition,” “[g]enerally speaking, antitrust law permits unilateral responses to competition.”

Recommendation 1 also states that “[p]rivate payors, governments, and providers should experiment further with payment methods for aligning providers’ incentives with consumers’ interests in lower prices, quality improvements, and innovation. See p. 21 of the FTC/DOJ Report, “Improving Health Care: A Dose of Competition.”

The Health Care Committee maintains a listserv to keep members informed of breaking developments in health care antitrust. You may join by going to the ABA’s website, or go directly to http://www.abanet.org/scripts/listcommands.asp?parm=subscribe/at-hcic and follow the instructions there.

The Health Care Committee compiles a list of articles that appear in law reviews and other publications on health care antitrust matters. This compilation, which goes back to the beginning of 2000, will be updated quarterly. At present it has references (and brief summaries) of over 65 such articles. The compilation is maintained on the Committee’s website at: http://www.abanet.org/antitrust/committees/counsel/commhealth.html