Federal Trade Commission

REMARKS OF JANET D. STEIGER

CHAIRMAN, FEDERAL TRADE COMMISSION

"FEDERAL ANTITRUST ENFORCEMENT FOR NOT-FOR-PROFIT ORGANIZATIONS"

THURSDAY, JUNE 28, 1990

LEGAL SEMINAR FOR NONPROFIT ORGANIZATIONS

HYATT HOTEL

MILWAUKEE, WISCONSIN

The views expressed in these remarks are those of Chairman Steiger. They do not necessarily represent the views of the Commission, or of any other Commissioner.

Good morning. It is a pleasure to be here this morning to discuss the application of the federal antitrust laws to non-profit organizations. My remarks this morning will focus on health care providers and institutions, because time is limited and this is the area where so much case law is developing. But let me assure you that the FTC is not overlooking other non-profit entities, particularly trade associations.

Before proceeding further, I want to make the usual disclaimer that the views I express here are my own and do not necessarily reflect those of the Federal Trade Commission or any other Commissioner.

The application of the antitrust laws to non-profit entities is developing. For many years, however, the courts have held that non-profit trade associations generally are subject to the provisions of the Federal Trade Commission Act.[1] In a series of cases testing the limits of the FTC Act, the FTC's jurisdiction over non-profit medical associations has also been sustained,[2] as has its jurisdiction over other non-profit associations.[3] Jurisdiction over other non-profit entities has been the subject of litigation, and I will describe two recent court opinions

---

[1] See, e.g., FTC v. Cement Institute, 333 U.S. 683 (1948).

[2] American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 447-48 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982) and 100 F.T.C. 572 (1982)).

[3] National Comm'n on Egg Nutrition v. FTC, 570 F.2d 157 (7th Cir.) cert. denied., 439 U.S. 821 (1978).

involving Justice Department actions against non-profit hospital mergers.

To understand federal antitrust enforcement against non-profit organizations, however, we must look first to the broader question of federal antitrust enforcement. As you know, both the Department of Justice and the Federal Trade Commission have jurisdiction in this area. For well over a decade, the Commission has been both active and innovative in pursuing its procompetition law enforcement mission in the health care area, and has been praised for this effort. I expect the Commission's active and aggressive program of law enforcement in the health care area to continue, and that we also will take an interest in new and different types of situations where antitrust enforcement can enhance competition and consumer welfare. As you know, in recent years, the health care services market has been changing rapidly. We have seen the emergence of such new arrangements and terms as "preferred provider organizations," "prudent buyer" programs, "physicians gatekeeper" programs, "health-care coalitions," and a host of others. We have also seen an evolution in the legal analysis regarding the application of the antitrust laws to non-profit organizations.

I will briefly describe the kinds of cases the Commission has brought in the health care sector and then discuss specifically the jurisdictional issues presented by non-profit organizations.

The objectives the Commission generally considers in deciding whether to bring an unfair competition case are threefold. First, and foremost, we seek to eliminate unlawful privately-imposed restraints on competition that substantially harm consumers, causing, for example, demonstrably higher prices for services, or reduced choices or availability of services. Because health care markets often are local in nature, some of our cases may involve actions by only a few individuals who possess nonetheless substantial power in the local market, so that their actions may have great impact on the welfare of consumers in those markets.

Second, the Commission seeks to send a message to different segments of the market, some of whom may never previously have been the subject of Commission action, that they in fact are subject to antitrust oversight. We still find situations where persons in the health care area are unaware -- or act as though they are unaware -- that the antitrust laws apply to their conduct.

Finally, the meaning and scope of the Sherman, Clayton, and Federal Trade Commission Acts have always depended upon their application to specific factual situations by law enforcers and courts since these laws are very broad and general in their terms. In health care, where the arrangements under scrutiny often are new or changing, and where the antitrust laws have been vigorously applied for only about 15 years, questions about the antitrust laws' proper application are frequent, and we strive to

clarify the law to serve as future guidance to those seeking to avoid antitrust problems.

What, then, are some of the specific areas of interest and activity for the Commission in health care? A primary area of concern is boycotts or concerted refusals to deal by competing health care practitioners. These generally take one of two forms. First, there are actual or threatened concerted refusals to deal aimed at purchasers and third-party payers of health care services. Such boycotts are intended to raise fee levels, and may either facilitate price-fixing outright or thwart purchasers' or payers' cost containment efforts. Second, there are concerted efforts to exclude entry by, or competition from, new or different practitioners or forms of organization that seek to compete with the established practitioners and practice arrangements.

The first type of boycott has long been the subject of Commission law enforcement action,[4] and will continue to be. Such conduct is almost always anticompetitive. It usually is

---

[4] See, e.g., Michigan State Medical Soc'y, 101 F.T.C. 191 (1983); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order); New York State Chiropractic Ass'n, D. 9210 (FTC consent order issued Nov. 11, 1988, 53 Fed. Reg. 52,405 (Dec. 28, 1988)); Patrick S. O'Halloran, M.D., Nos. C-3232 to C-3237 (FTC consent order issued Aug. 26, 1988, 53 Fed. Reg. 48,531 (Dec. 1, 1988)); Indiana Dental Ass'n, 93 F.T.C. 392 (1979) (consent order); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order); Texas Dental Ass'n, 100 F.T.C. 536 (1982) (consent order); Indiana Fed. of Dentists, 101 F.T.C. 57 (1983), rev'd, 745 F.2d 1124 (7th Cir. 1984), rev'd, 476 U.S. 447 (1986); Eugene M. Addison, M.D., No. C-3243 (FTC consent order issued Nov. 15, 1988, 53 Fed. Reg. 52,679 (Dec. 29, 1988)).

either per se illegal, or will require only a limited inquiry in order to be found to be illegal. Commission investigations of this type of conduct are ongoing.

While we at the Commission sometimes call this kind of conduct the "common" or "garden variety" type of boycott, in the health care area this designation may be somewhat misleading. While the general legal principles in such boycott cases are clear, these cases often differ substantially in their factual settings, and sometimes raise novel issues.

Until recently, for example, relying on the First Amendment, some argued that a different standard of antitrust review applied when the boycott target was a governmental entity, such as Medicare or Medicaid, and the boycott was intended, at least in part, to publicize the boycotters' position in order to help convince the governmental purchaser to accede to their demands. That issue was squarely faced this year by the Supreme Court in the Commission's Superior Court Trial Lawyers Association case, which involved a group of lawyers seeking higher fees from the government for representing indigent defendants in criminal cases.[5] When the government refused to raise their fees, the lawyers, acting as a group, refused to take any more cases. The Court rejected the argument that some proof of market power should be required if a case concerned an economic boycott with

---

[5] Superior Court Trial Lawyers Ass'n, 107 F.T.C. 510 (1986), vacated & remanded, 856 F.2d 226 (D.C. Cir. 1988), rev'd and remanded, ___ U.S. ___ (No. 88-1393) (Jan. 22, 1990).

an "expressive component", and went on to hold that the horizontal boycott by the group was per se illegal. This was so even though it was recognized that the lawyers were very poorly compensated and serving a disadvantaged group -- poor people charged with crimes who could not afford a lawyer.

The second general type of boycott case that the Commission is, and will be, pursuing involves concerted efforts to exclude new competitors, such as non-physician health care providers, or new or different forms of competition, such as HMOs, PPOs, multi-specialty clinics using salaried physicians, or numerous other types of "alternative" health care arrangements that are developing with such frequency that it is difficult to keep track of all their forms and variations. These "alternative" providers and novel oftenarrangements present consumers with additional choices in obtaining and paying for their health care services. They also exert competitive pressure on existing providers and provider arrangements in the market.

Besides boycotts, another area of Commission activity -- both in the past and currently -- is hospital mergers. You may already be familiar with the Commission's successful challenges to mergers involving American Medical International, Inc., and Hospital Corporation of America, both for-profit hospital chains.[6] Recently, however, there has been a spate of mergers

---

[6] American Medical Internat'l, Inc., 104 F.T.C. 1 (1984) (order modified 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986)); Hospital Corp. of America, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987);
(continued...)

involving non-profit hospitals, and the Commission has challenged those that we believe may be potentially anticompetitive. In two instances, the Commission has found reason to believe that hospital mergers could have the potential for impairing competition and consumer welfare even where those hospitals are non-profit institutions. One of those cases, the Reading Hospital and Medical Center consent order,[7] was finalized by the Commission last month.

The second case, Ukiah Adventist Hospital,[8] is in litigation and I am, therefore, unable to discuss it. Although the Commission's ultimate authority under the Clayton Act to regulate non-profit organizations has not been definitively established, cases currently in litigation, like Ukiah, may illuminate the issues for the Commission, the parties, and the public.

The question of whether non-profit hospitals and other organizations should receive the same kind of antitrust scrutiny as their for-profit counterparts has been raised most prominently in the Justice Department's two recent hospital merger cases. The question, however, is neither new nor limited to merger cases. Indeed, it was first addressed by the Supreme Court in

---

[6](...continued)
Hospital Corp. of America, 106 F.T.C. 298 (1985) (consent order modified 106 F.T.C. 609 (1985)).

[7] Dkt. No. C-3284, May 2, 1990.

[8] Dkt. 9234 (complaint issued Nov. 7, 1989).

1984 in a non-merger case, National Collegiate Athletic Ass'n v. University of Oklahoma[9]. In that case, the Court affirmed lower court decisions that the National Collegiate Athletic Association violated the antitrust laws by restraining its members' sales of television broadcast rights of college football games. The Court gave little weight to the fact that these restraints were imposed by an association of public and private non-profit educational institutions, refusing either to infer a generally applicable antitrust exemption for non-profit firms or to apply a relaxed standard of antitrust scrutiny. Its opinion noted that the NCAA and its members' athletic programs sought to maximize revenues, and found it unclear that they would be any less likely than for-profit entities to raise prices and revenues above what they could obtain in a competitive market.

A somewhat similar issue arose in connection with the Federal Trade Commission's challenge to hospital acquisitions in the Chattanooga, Tennessee area by HCA -- the Hospital Corporation of America. The HCA and the firms it acquired were all for-profit enterprises. However, HCA argued that its market share of less than 30% did not allow it to raise prices above competitive levels without the cooperation of its major competitors, and such cooperation was improbable because those competitors were non-profit hospitals (including two public hospitals) which did not share HCA's profit-maximization

---

[9] 468 U.S. 85 (1984).

objectives. The Commission and the Seventh Circuit Court of Appeals, which affirmed the Commission's divesture order against HCA, both disagreed with this argument.

The Commission's opinion noted that non-profit hospitals, like their for-profit counterparts, may not be content with the revenues and net incomes allowed them by a competitive market, and may be similarly inclined to engage in anticompetitive conduct even though their goals do not include enhancing shareholders' interests. Additional revenue and income may help them, for example, to maintain or add facilities and equipment, provide more charity care, enhance their institutional prestige, or improve the salaries and working conditions of hospital employees.

As the Commission recognized, fulfillment of these objectives might be particularly difficult in a competitive market subject to cost-containment pressures from third-party payers, giving hospitals numerous incentives to use their market power (individual or collective) to resist those pressures. However beneficent the objectives of the hospitals may be, they would be achieved at the expense of health care consumers, that is, patients and their health coverage providers. The Commission buttressed this conclusion with evidence of past anticompetitive cooperation involving non-profit hospitals in the Chattanooga market, including a market allocation agreement between a for-profit hospital and a non-profit hospital. It also noted that the need of the area's two public hospitals for income to satisfy

their obligations to care for the indigent, without calling for additional support from taxpayers, made those hospitals particularly unlikely to resist the temptation to band together with competitors to keep hospital prices high.

The Seventh Circuit agreed with the Commission that it was only "conjectural" that the non-profit hospitals in Chattanooga would serve as a safeguard against the potential anticompetitive effects of HCA's acquisitions. Judge Richard Posner, writing for the court, observed that the "the adoption of the non-profit form does not change human nature" -- including the common human tendency to dislike competition and the inclination to do away with it when it gets in the way of one's goals. The court acknowledged that public hospitals face political pressures to keep prices down, but also countervailing pressures to keep prices up in order to keep taxpayer subsidies down, as well as other political constraints which may limit their practical ability to undermine monopoly pricing by other hospitals.

This issue was revisited in somewhat different form in two recent Justice Department hospital merger cases, which involved roughly similar transactions and markets. The Justice Department has so far been successful in its challenge to the proposed merger of two non-profit hospitals in Rockford, Illinois[10], but not in its challenge to a proposed merger of two non-profit

---

[10] United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), aff'd, 1990-1 Trade Cas. (CCH) 68,978 (7th Cir. 1990).

hospitals in Roanoke, Virginia[11]. Both the Department's win in the Rockford case, and its loss in the Roanoke case, have been affirmed by different appellate courts (though Supreme Court review of the Rockford case remains a possibility). And in both cases, prominent among the hospitals' arguments was that the prospect of anticompetitive effects was substantially mitigated not only by their non-profit status, but also by control of their boards of directors by local civic leaders and particularly by executives whose companies' employee health plans were significant purchasers of the hospitals' services -- in short, the hospitals are essentially "buyer cooperatives."

The district court in the Roanoke case adopted this argument as one of its many reasons for concluding that the proposed merger before it would not substantially endanger competition. It cited economic testimony that non-profit hospitals tend to have lower charges than their for-profit counterparts, as well as testimony (based on studies focusing on non-profit hospitals) that hospital prices are lower in areas with fewer hospitals. The court also expected that the business leaders on defendants' board of directors would force the hospitals to pass along to consumers (including their own businesses) the cost savings the court anticipated from the merger. The Fourth Circuit Court of Appeals declined to overrule the district court, holding that its general conclusion that the merger would not be anticompetitive

---

[11] United States v. Carilion Health System, 707 F. Supp. 840 (W.D. Va.), aff'd mem., 892 F.2d 1041 (4th Cir. 1989).

was not "clearly erroneous." However, the appeals court did not address the significance of defendants' non-profit character. Additionally, the court of appeals refused to permit its decision to be published, thereby limiting its precedential value.

The district and appellate courts in the Rockford Illinois case reached a different result. The district court, in addition to following the Seventh Circuit's general analysis in the HCA case, cited evidence specific to the case before it as reasons to question defendants' commitment to consumer interests. It placed particular emphasis on evidence that the three non-profit hospitals in Rockford had formed a "united front" to boycott the local Blue Cross plan in a partially successful effort to block proposed reductions in Blue Cross reimbursement levels. The district court also found that the desire to reduce competition among the three Rockford hospitals was a contributing factor to the defendants' decision to pursue merger.

The Seventh Circuit's decision in April affirming the district court, also written by Judge Posner, emphasized different factors but reached similar conclusions. The appeals court pointed out that people generally prefer not to compete with others if they can avoid it, and that this tendency might be even stronger among non-profit firms given their typical philosophical bias in favor of cooperation rather than competition. The court, therefore, was unwilling to rely on defendants' non-profit character as a basis for rejecting the presumption that anticompetitive effects would flow from

defendants' very high post-merger share of a market in which entry was difficult, at least on the basis of defendants' evidence and what the court considered to be "early and inconclusive" economic evidence on the validity of the market share presumption in the hospital industry.

These cases highlight many of the considerations that support the general treatment of non-profit entities like their for-profit counterparts when applying the merger and other antitrust laws. In addition to hospital mergers, the Commission also is looking at the competitive effects of other mergers in the health care area. While our primary emphasis is on institutional health care providers, such as nursing homes, in appropriate circumstances even the merger of private physician practices may raise competitive concerns and be the subject of antitrust scrutiny by the Commission.

We also are actively looking at certain vertical arrangements in the health care area, i.e., between two different levels in the overall process of providing health care services, such as arrangements or affiliations among hospitals, HMOs and insurers. While many vertical arrangements actually are efficient and may benefit consumers by reducing costs or improving convenient access to goods and services, some vertical arrangements may be anticompetitive in purpose or effect. Additionally, we are looking at certain types of tying arrangements, such as where a provider's market power in one area of services is used to force

patients to use a related service where the provider is only one of several competitors in the second market.

Finally, we continue to look at restraints imposed by provider groups, such as professional associations, on truthful advertising or other information dissemination by their members. The Commission has challenged anticompetitive private restraints on truthful advertising beginning with the AMA case,[12] and continuing through the present. I firmly believe that in health care, as in other areas of the economy, effective competition depends upon the availability of such truthful information, which permits consumers to make informed choices about the purchase of goods and services, and the providers of those goods and services. We also recognize the importance of prohibiting false and deceptive advertising. Thus, in the AMA case, and every other case involving advertising regulation by a state board or professional society, the Commission's order specifically permits the respondent to adopt and enforce rules preventing false or deceptive advertising.

In conclusion, I hope that I have given you an overview of the application of the antitrust laws in the health care sector and why the federal agencies, and the courts that enforce the antitrust laws, have reason to be concerned about the possible anticompetitive effects of mergers and other conduct by non-profit hospitals and other health care institutions. The

---

[12] See n. 2, supra.

agencies and courts are expressing increasing skepticism about the notion that the absence of a conventional profit motive, or other characteristics of non-profit firms, means that their conduct is much less likely to injure consumers than similar conduct in the for-profit sector. Cases now in progress and future cases will clarify these issues.

Thank you.