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Towards a Competitive Health Care System

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TOWARDS A COMPETITIVE HEALTH CARE SYSTEM

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I am pleased to be here today. The usual caveats apply to my comments: what I say is my own opinion and does not necessarily reflect the position of New York Attorney General Dennis C. Vacco, the New York State Department of Law, or any other Attorney General.

As an antitrust prosecutor, I was somewhat puzzled by an invitation to speak on a program entitled healthcare, Poverty, and Autonomy. Although I consider what I do as serving the public interest for all New Yorkers, including poor New Yorkers, I usually do not speak on or attend programs with poverty or autonomy in the title. I do not know whether you believe the forces of competition I espouse represent a breath of fresh air or a destructive hurricane. In any case, I apologize in advance if I speak with a different vocabulary.

Before I begin, I note that emotions run high in discussions about healthcare markets. Dramatic changes are underway and grave uncertainties exist in healthcare markets. The ways in which people secure and finance healthcare are rapidly changing. Everyone worries whether affordable quality healthcare services will be available to them. Many in the industry have suffered through significant personal and professional changes. Institutional survival of hospitals and other healthcare businesses is often at stake. Given these dynamic forces, asking whether the poor will receive affordable quality health care or be lost in the turmoil is a fair question.

I believe that fostering competition is the best way to relieve poverty and enhance individual autonomy, that is patient choice, in healthcare markets. The antitrust laws constitute the foundation and fundamental strength of our democratic free enterprise system. To quote the United States Supreme Court, the antitrust laws rest "on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material pro-

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gress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions."[1] Competition enhances both our democratic and economic strengths and opportunities, and provides the means to continue and build upon those strengths and opportunities. The Supreme Court and I both believe these principles apply in all markets, including healthcare markets.[2]

I respect and recognize that a competitive system is not the only choice that the government can make. I also note that for years, New York chose to displace the antitrust laws and impose a regulatory system in healthcare markets.[3] The economic literature contentiously debates whether competition or regulation better achieves higher quality and lower costs.[4] Yet, I remain steadfast in the belief that a competitive system works best. The overall strength of our economy is testimony to that belief.

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1. Northern Pacific Railroad Co. v. United States, 356 U.S. 1, 4 (1958). The Court defined the antitrust laws as "a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." *Id.*; *see* United States v. Topco Associates, Inc., 405 U.S. 596, 610 (1972) ("Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise."). To quote New York's highest court, the antitrust laws promote a public policy "of the first magnitude." LaRossa v. Abrams, 62 N.Y.2d 583, 589, 468 N.E.2d 19, 22, 479 N.Y.S.2d 181, 184 (1984) (quoting Aimcee Wholesale Corp. v. Tomar Products, Inc., 21 N.Y.2d 621, 625, 237 N.E.2d 223, 224, 289 N.Y.S.2d 968, 970 (1968)).

2. *See, e.g.*, American Medical Ass'n v. United States, 317 U.S. 519 (1943); Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982); Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447 (1986).

3. There are significant limitations on what a state can do to displace competition, which in antitrust parlance is called the state action doctrine. The state action doctrine illustrates the tension between the supremacy of federal antitrust laws and federal deference to states under principles of federalism. A state cannot directly shield private parties from the reach of the federal antitrust laws because a state lacks the authority to repeal federal antitrust law. Consistent with notions of federalism, however, the state action doctrine allows a state to: (1) regulate without fear of federal antitrust liability; and (2) expect private compliance with that regulation, even if compliance might otherwise violate the federal antitrust laws. The active state supervision prong of the state action doctrine in effect prevents a state from indirectly repealing the federal antitrust laws without replacing them with a fully implemented, regulatory scheme. In short, a state can indirectly limit the reach of the federal antitrust laws only by enacting and actively supervising a regulatory scheme. For a more traditional description of the state action doctrine, *see* Sarah Vance, *Immunity for State-Sanctioned Provider Collaboration After Ticor*, 62 ANTITRUST L.J. 409, 411-20 (1994).

4. *Compare, e.g.*, James Robinson & Harold Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 23 JAMA 3241 (1987) (arguing that prices are higher for hospitals in competitive markets) *with* Glenn Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992) (arguing that prices are lower for hospitals in competitive markets).

Healthcare markets still have regulations that strike me as illogical and anticompetitive. For example, as an antitrust lawyer, I just do not accept the reasoning behind Certificate of Need (hereinafter CON) laws.[5] Under CON laws, before you build a big ticket medical item, like a heart institute, you have to establish for the state that the community needs a heart institute.[6] Antitrust lawyers try to eliminate, rather than formalize and erect barriers to new entry into markets. You do not have to convince some governmental body of a need before you build a building or start a business, but you do (under CON laws) before you build a heart institute. For the life of me, I cannot understand why society appropriately allows many frivolous things while it has a policy, as set forth in CON laws, against too many useful things like heart institutes.

Nonetheless, the New York State Legislature generally has decided that competition should be the driving force in healthcare markets.[7] After years of the state setting the reimbursement rates and other aspects of the revenue of hospitals, those rates are now set by negotiation between hospitals and purchasers.[8] Numerous benefits are already evident. For example, I am heartened to read that hospitals and other healthcare providers now compete for patients, including Medicaid patients.[9] Government is not really capable of imposing anything more than minimum standards. Applying the antitrust laws aims for higher than minimum standards. No regulatory system can deliver the quality provided by the choice among alternatives. Applying the antitrust laws fosters patient choice, rather than government or doctor control. With choice, healthcare consumers can choose better (not just minimally acceptable) healthcare services.

From my perspective, the question to pose is what can be done to make competition work better. Healthcare markets have significant market imperfections. For example, to be effective the antitrust laws depend upon the flow of market information. Yet, because third party payers dominate healthcare markets the usual flow of information about "value" or "quality" just does not occur. The economic incentives for health care consumers do not foster

5. *See* N.Y. PUB. HEALTH LAW § 2802 (McKinney 1993).

6. *Id.* at § 2802(2).

7. 1996 N.Y. Laws ch. 639 § 1.

8. Elisabeth Rosenthal, *Hospitals Start Open Competition Under a New Law*, N.Y. TIMES, Jan. 1, 1997, at A1.

9. *See id.*

competitive changes as well as when third party payers are involved. Co-payments and deductibles do not foster competition as directly as direct payment by the purchasers of healthcare would.

Moreover, even the most basic frames of reference are not available in healthcare markets. Information on the long term effects of various regimens of treatment are simply not available in a form that allows a purchaser of medical services to make an informed decision on which regimen to choose. This selection is a difficult task primarily because human health is both complicated and influenced by many factors. Take, for example, back pain. Some doctors urge bed rest. Others recommend surgery to relieve the pressure that vertebrae inflict on the nerves. Chiropractors do something else entirely different. No cogent analysis demonstrates or will demonstrate soon which of these regimens work best. Healthcare markets would benefit from developing procedures of gathering information to improve the flow of information. I think we will continue to do better and recognize that more and more procedures to measure value and quality of healthcare services are being developed and standardized.