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**Statement of David Balto, Senior Fellow
Center for American Progress Action Fund**

**Before House Committee on Ways and Means,
Subcommittee on Health
on
“Health Industry Consolidation”**

September 9, 2011

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Chairman Herger, Ranking Member Stark, and other members of the committee, I appreciate the opportunity to come before you today and testify about health care industry consolidation—a subject of significant concern. As a former antitrust enforcement official who has litigated a number of cases challenging anticompetitive conduct and proposed mergers in the healthcare industry as well as a private practice attorney who has represented insurance companies, hospitals, pharmacies, and other healthcare providers in merger investigations, I have a learned firsthand of the harm of excessive concentration in healthcare markets. Highly concentrated healthcare markets, especially health insurance markets, can result in escalating healthcare costs for the average consumer, a higher number of uninsured Americans, an epidemic of deceptive and fraudulent conduct, and supracompetitive profits. My time at the antitrust enforcement agencies has also showed me that we need to draw a clear distinction between problematic consolidations on the one hand, and the efficient integration of our health system on the other. For antitrust enforcement to serve as a tool for and not an obstacle to improving our healthcare system, we must understand this distinction and realign enforcement priorities to focus on the forms of market consolidation that pose harm to the ultimate consumers.²

Three realities that both policy makers and antitrust enforcers need to embrace include:

- **Health Insurance Markets Are Broken**—more than 90 percent of all metropolitan health insurance markets are highly concentrated. The healthcare debate and countless Congressional hearings have documented how this extreme concentration results in higher prices, millions of uninsured consumers, and a pattern of egregious conduct by health insurers. Greater focus needs to be directed towards consolidation in health insurance markets.
- **Aggregation is Distinct from Integration**—If there is a competitive problem in healthcare markets, it is due to aggregations of market power, such as in health insurance, and not because of integration among physicians. Rather than the problem, integration is an important solution for improving quality and cost in the fee-for-service healthcare system. So as not to thwart the much needed reform of our healthcare system, antitrust resources should be directed towards concerns of market power by health insurers, hospitals, and specialized physician groups. A lesson to be learned from the Affordable Care Act is that

¹ I am former policy director of the Federal Trade Commission and was actively involved in several health care matters and revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care in that role. This testimony represents solely my views.

² Antitrust enforcement is shared between the Antitrust Division of the Department of Justice and the Federal Trade Commission. Both agencies investigate healthcare providers, but the DOJ has primary jurisdiction over insurers.

facilitating integration can be used as an effective mechanism to combat the excessive costs and poor health care outcomes often resulting from the lack of coordination among health care providers.

- Healthcare markets are distinct and enforcers need to appropriately adapt the antitrust models used to evaluate them. The price-centric antitrust framework is rather inapt in healthcare markets where price is often an insufficient mechanism for fully understanding the impact of a given market structure or business practice. Moreover, the prevailing perception that insurers are the central customer in healthcare markets creates a framework for evaluating the healthcare system that ignores the ultimate impact on consumers. Antitrust enforcers need to amend their approach to healthcare markets to focus on the impact on the ultimate consumer and not just the payment intermediary.

These realities directly undermine the underpinnings of the current antitrust paradigm in healthcare. That paradigm assumes that healthcare intermediaries, such as health insurers or pharmacy benefit managers (PBMs), are an appropriate proxy for the consumer in healthcare markets. The paradigm assumes that consumers will be better off if health insurers can use their power to drive down reimbursement rates relentlessly. It suggests that it is necessary to harbor deep suspicion over collaboration by doctors. Antitrust agencies appear to prefer a system of autonomous providers, who are fundamentally powerless to deal with insurance companies.

Let's just deal with one of these notions: the belief that the market will perform better with powerful insurers and autonomous and unintegrated providers, especially doctors. If your main concern is the bottom line for health insurers, this notion may theoretically sound appealing. But this paradigm presents two significant problems for healthcare and consumers. First, doctors acting autonomously are unable to effectively coordinate care – the “silo” problem that leads to more costly and less efficient care and delivers poorer health outcomes. The healthcare debate clearly demonstrated that a lack of integration led to more costly and lower quality care. Second, autonomous providers are too weak to bargain with insurance companies leading to increasingly reduced reimbursement and assembly line healthcare. Insurance companies may benefit from lower reimbursement but consumers suffer through more expensive and lower quality care.

In fact, consumers and public welfare as a whole may be better off if providers, especially doctors and pharmacies, can band together to have some level of countervailing power to deal with powerful insurers. Former Republican Congressman Tom Campbell in a series of thoughtful law review articles has demonstrated that permitting sellers of service or good to merge may improve welfare when dealing with powerful buyers.³ You may recall that a decade ago he called for legislation to grant doctors the ability to collectively negotiate with insurers.

More concretely, countervailing power for doctors and pharmacies may benefit consumers. These providers are often the most effective advocates for patients when insurance companies cross the line and engage in abusive and deceptive conduct. Doctors can use their negotiating power to prevent insurers from implementing “physician gag” clauses which prevent physicians from informing consumers about insurance options. Doctors can use their power to

³ See Tom Campbell, *Bilateral Monopoly in Mergers*, 74 ANTITRUST L.J. 521 (2007); see also Tom Campbell, *Bilateral Monopoly -- Further Comment*, 75 ANTITRUST L.J. 647 (2008).

challenge deceptive conduct that harms both consumers and providers. Take the Ingenix case as an example – where United Healthcare’s subsidiary deflated usual and customary rates harming millions of consumers.⁴ It was associations of doctors including the AMA that led the charge in exposing these practices, leading to a landmark remedy and over \$350 million in damages to date.

What about the idea that the insurer or the PBM is the consumer? Insurers and PBMs do attempt to control costs for employers and other purchasers of health plans. While these entities may attempt to control cost they are also for-profit entities with an overriding incentive to maximize profits. When there are battles between healthcare providers and insurers, the agencies almost always weigh in on the side of the insurers. But insurers are not the consumers. The endless list of competition and consumer protection cases against insurers and PBMs show that health insurers and PBMs frequently act to harm consumers. The primary goal of these for-profit insurers and PBMs is to serve their shareholders and their profit margins, and not consumers. They are not the representatives of consumer interest.

This was recognized in a decision last fall by the Third Circuit in a case challenging anticompetitive conduct against Highmark, the dominant insurer in Pittsburgh. Highmark attempted to justify alleged anticompetitive conduct that reduced reimbursement to a hospital, arguing that it did not pose antitrust problems because it enabled Highmark to set low insurance premiums and thus benefitted consumers. The Third Circuit rejected that claim:

[E]ven if it were true that paying West Penn depressed rates enabled Highmark to offer lower premiums, it is far from clear that this would have benefitted consumers, because the premium reductions would have been achieved only by taking action that tends to diminish the quality and availability of hospital services.⁵

The court went on to explain that the purpose of the antitrust laws is to ensure a competitive marketplace and that a reduction in competition is not permitted simply because it may appear to lead to lower prices. This can be a profound observation in healthcare where quality of care is a central concern.

It is time for our antitrust enforcers and policy makers to recognize the lessons from healthcare reform and adapt the antitrust paradigm. As I have documented in a Center for American Progress study, the history of healthcare antitrust enforcement in the past administration is characterized by largely misplaced enforcement priorities.⁶ Although health insurance markets are plagued by anticompetitive and abusive conduct, there were no competition or consumer protection enforcement actions against health insurers. At the same

⁴ Testimony of David A. Balto, “The Effects of Regulatory Neglect on Health Care Consumers” before the Senate Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

⁵ *West Penn Allegheny Health System v. UPMC and Highmark, Inc.*, 2010 U.S. App. LEXIS 24347, at *40 (3d Cir. 2010).

⁶ Testimony of David A. Balto, “The Need for a New Antitrust Paradigm in Health Care” before the House Judiciary Committee, Subcommittee on Courts and Competition Policy on Antitrust Laws and their Effects on Health Care Providers, Insurers, and Patients (July 16, 2009).

time almost all of the FTC healthcare enforcement actions were against efforts by physicians to collectively negotiate. Physician collaboration has been living as a suspect class and represents the only area where antitrust agencies apply the “per se” label and condemn endeavors without analysis of anticompetitive effects. (The “per se” rule is the legal guillotine of the antitrust laws. Under the per se rule, the government need not demonstrate the conduct has harmed competition or consumers.) The FTC brought 31 cases, all settled, probably because of the high cost of a government investigation. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did consumers file any antitrust suits seeking damages for the alleged illegal conduct. (There was only one case filed by an insurer and it lost.)⁷ This disproportionate focus on physician groups was supported by no evidence that higher physician costs were a significant force in escalating health care expenditures.

My testimony today highlights how those enforcement priorities have changed and what else needs to be done to address competitive problems in healthcare markets. It begins with observations about health insurance concentration, certainly the most chronic and severe competitive problem in the market. The testimony describes increased prudent antitrust enforcement aimed at addressing those both the problems of increased consolidation and anticompetitive practices. It then focuses on problems in concentration among healthcare providers, primarily hospitals, and addresses renewed enforcement efforts. It addresses how the Affordable Care Act offers the potential to significantly spur health care competition and closes with several recommendations to strengthen healthcare antitrust enforcement.

This hearing focuses on concentration in the healthcare industry and it is important to recognize that antitrust law is an important but limited tool for fighting concentration. Antitrust enforcement rarely, if ever, can be used to “deconcentrate” a market. Rather, antitrust enforcement can simply prevent further concentration through merger enforcement under the Clayton Act, and can prevent actors in an already concentrated industry from acting anticompetitively through enforcement of the Sherman Act. Thus, antitrust is a limited weapon against the harms of market concentration.

Adapting the Antitrust Paradigm: Focusing on Health Insurance Consolidation

Concerns over healthcare consolidation should focus on the need to prevent increases in concentration by health insurers. Insufficient focus on this area in the past has given way to a very poorly functioning health insurance market. Few markets are as concentrated, opaque, and as conducive to deceptive and anticompetitive conduct. Congress has recognized time and again these markets as lacking in sufficient competition and transparency, so I will not detail the mountain of evidence pointing to their ineffective function, but I would like to highlight why the lack of competition and effective transparency in health insurance markets is so problematic.

⁷ In contrast, in one of the few DOJ cases – a challenge to an association of Arizona hospitals that had agreed to depress the wages of traveling and visiting nurses – there was successful private litigation which led to a proposed settlement of over \$23 million in damages for a class of harm to nurses. (*Doe v. Arizona Hospital and Healthcare Association*, Case No. 07-cv-1292 ([D.AZ.](#))) I was co-lead attorney for the class of nurses.

There are three necessary components of a functioning market: choice, transparency, and a lack of conflicts of interest.⁸ Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these three elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: a recent report by Health Care for America Now found that in 39 states two firms control at least 50 percent of the market and in nine states a single firm controls at least 75 percent of the market. A 2009 AMA study found almost 99 percent of all markets are highly concentrated. Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but just follow the lead of the price increases of the larger firms.

In the last session Congress heard from scores of consumers about the harms from this dysfunctional market. The number of uninsured patients has skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn't really protect them. In the past six years alone, health insurance premiums have increased by more than 87 percent, rising four times faster than the average American's wages. Healthcare costs are a substantial cause of three out of five personal bankruptcies. At the same time from 2000 to 2007, the 10 largest publicly-traded health insurance companies increased their annual profits 428 percent, from \$2.4 billion to \$12.9 billion.

Empirical economic studies have also documented the harm from health insurance concentration. A recent study documented how concentration in various Texas markets led to higher premiums of about 7%.⁹ The study also concludes what most of us know as the truth: the increase in concentration has led to lower premiums paid to healthcare providers, and has also contributed to the substitution of nurses for doctors in many markets. Thus, we are seeing concentration negatively impact the economics of the healthcare industry, as well as the quality of care received by the American consumer.¹⁰

The Express Scripts-Medco Merger

The pharmacy benefit manager, or PBM, market is another example of a highly concentrated intermediary market. I have testified in the past about how this market does not behave competitively and remains the only unregulated segment of today's healthcare market. Just three players—Medco Health Solutions, Express Scripts, and CVS Caremark—dominate

⁸ Testimony of David A. Balto, "The Effects of Regulatory Neglect on Health Care Consumers" before the Senate Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

⁹ Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry, *American Economic Review*, forthcoming, at 32, available at <http://www.kellogg.northwestern.edu/faculty/dafny/personal/>.

¹⁰ *Id.* at 31.

this market. These big three PBMs have engaged in deceptive, fraudulent, and egregious conduct and limited market competition – in the past 6 years the three major PBMs have settled 5 major cases brought by state attorneys generals resulting in over \$370 million in penalties and fines.¹¹

The recently proposed acquisition of Medco by Express Scripts, which is under investigation by the FTC, threatens competition and will lead to significantly reduced competition and higher costs for individual consumers, employers, and Federal programs such as TRICARE and Medicare Part D. The merger will further aggregate this market and create a dominant PBM with approximately 155 million covered lives and over 50% of the large employer market.¹² To put that number in context, a combined Express Scripts-Medco will cover 70 million more lives than the next largest PBM. This merger will significantly limit competition among pharmacy benefit managers and poses harm to consumers, plans, employers, unions, and pharmacies.

A particular concern is for the millions of consumers who depend on specialty drugs to treat their chronic, incurable and potentially life-threatening illnesses. Through vertically integrated models, Express Scripts and Medco also own the two largest specialty pharmacy businesses. This deal would give the joint company over a 50 percent share of the specialty pharmacy market¹³ and further restrict pharmacy competition which today is based on quality service, clinical support for patients/caregivers and other non-drug, non-price features. Specialty pharmacies provide treatments for our nation's most vulnerable patient populations suffering from complex conditions such as hemophilia, Crohn's Disease, hepatitis C, infertility, HIV/AIDS, and many forms of cancer. The specialty treatments for these conditions are generally very expensive, costing an average \$1,867 per drug¹⁴ and often require special handling and control, complex administration, and intensive and consistent patient monitoring. The services provided by specialty pharmacies support the most cost-effective use of these expensive treatments and help to keep these patients healthy and out of hospitals and emergency rooms. This merger threatens these important services provided by specialty pharmacies as well as creates challenges for new, innovative specialty drugs to enter the market. Further consolidation of these markets would significantly harm pharmacies as well as the vulnerable patients that rely on their services, and would hamper any efforts to contain pharmaceutical costs. The FTC should block this merger to protect competition in the PBM and specialty pharmacy markets.

This committee should be particularly concerned about the impact of the merger on government healthcare programs such as Medicare Part D, the FEHBP, and Tricare, for example. These federal programs are heavily dependent on the big three PBMs and competition among the PBMs is crucial to controlling government drug expenditures. The merger will significantly reduce competition for these government programs and threaten to increase the government's

¹¹ Testimony of David A. Balto on Section 408(b)(2) Regulation Fee Disclosures to Welfare Benefit Plans before Employee Benefits Security Administration U.S. Department of Labor (December 7, 2010).

¹² I currently represent several consumer organizations, as well as the Independent Specialty Pharmacy Coalition and the National Coordinating Committee for Multi-Employer Plans (NCCMP) before the FTC on this issue. NCCMP represents 10.4 million participants in defined benefit pension plans and 26 million Americans who receive coverage from multi-employer health welfare plans. This testimony represents solely my views.

¹³ Pembroke Consulting 2010-2011 Economic Report on Retail and Specialty Pharmacies.

¹⁴ *Id.* at 12.

expenditures in providing drug benefits for employees and retirees. Moreover, it will limit access to high quality specialty pharmacy services for millions of consumers nationwide.

Recent Revitalization in Healthcare Antitrust Enforcement

The Bush administration failed to challenge any mergers or anticompetitive conduct by health insurers during the entirety of its tenure,¹⁵ but under President Obama we have seen a revitalization of health insurance antitrust enforcement.

Enforcement Actions Against Health Insurers

The record on past enforcement in health insurer mergers was stark. In the past administration there was a tsunami of mergers, leading to further concentration in the industry. There were no competition or consumer-protection enforcement actions against health insurers in the last administration, despite the fact that anticompetitive and abusive conduct plagued some health insurance markets. There were more than 400 mergers and the DOJ required the restructuring of just two of those mergers.

The tide changed in 2010 when the Department of Justice presented the first government challenge to a merger of health insurers when Blue Cross Blue Shield of Michigan agreed to acquire competitor Physicians Health Plan of Mid-Michigan. The Department determined that this acquisition would result in BCBS controlling nearly 90% of the market for commercial Michigan health insurers. It further concluded that this acquisition would result “in higher prices, fewer choices, and a reduction in the quality of commercial health insurance plans purchased by Lansing area residents and their employers.”¹⁶ As a result of this concentration and likely anticompetitive results, the DOJ announced its intention to enjoin the merger. Facing this announcement, the parties agreed to abandon their deal, leaving intact competition between the two insurers. This was the first time the DOJ threatened to go to court to block a merger and their willingness to litigate made a difference.

Equally pernicious can be practices by dominant insurers that limit the ability of other insurers to enter or expand in the market. One such practice is a Most Favored Nation clause (MFN), which requires the seller of a service to provide the best price to a buyer. Generally these can be procompetitive, but when used by a dominant insurer they can forestall entry. An MFN requires a hospital to provide an insurer its best price, and can prevent other health insurers from entering into the market. These provisions escalated prices and increased entry barriers in the commercial insurance market. The DOJ sued Blue Cross of Michigan for its aggressive use of MFNs.¹⁷ According to the complaint, Blue Cross used MFN provisions or similar clauses in its contracts with at least 70 of Michigan's 131 general acute-care hospitals, including many major hospitals in the state. The complaint alleges that the MFNs require a hospital either to

¹⁵ I have testified in the past about the mistaken enforcement priorities under the Bush administration and have listed the misguided actions taken against groups of healthcare providers, typically small and rurally located, with no significant impact on consumers. Please refer to my testimony, “The Need for a New Antitrust Paradigm in Health Care” for more additional information.

¹⁶ DOJ Press Release, *Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans*, March 8, 2010, available at, http://www.justice.gov/atr/public/press_releases/2010/256259.htm

¹⁷ *U.S. v. Blue Cross Blue Shield of Michigan*, Case No. 10-cv-14155 (E.D. Mich. 2010).

charge Blue Cross no more than it charges Blue Cross's competitors, or to charge the competitors more than it charges Blue Cross, in some cases between 30 percent and 40 percent. In addition, the complaint alleges that Blue Cross threatened to cut payments to 45 rural Michigan hospitals by up to 16 percent if they refused to agree to the MFN provisions.

The effects of these agreements are numerous, including: raised prices for commercial health insurance; restricted competition among health insurer providers; restricted choice by Michigan-area hospitals; and, ultimately, less hospital services available to consumers. Blue Cross lost on its motion to dismiss the case just last month, as the court concluded that the government sufficiently alleged plausible markets, anticompetitive effects, and a legal theory of harm.

The DOJ, assisted by several state attorneys generals, has ongoing investigations of MFNs by dominant insurers in several states.

Enforcement Actions Against Healthcare Providers

Much of the focus of today's hearing is on concerns about market power by healthcare providers – both hospitals and doctors. Although it is easy to generalize concerns, or focus on colorful anecdotes, these concerns should be put in perspective.

- Both the FTC and DOJ devote considerable resources to healthcare and investigate dozens of provider mergers, joint ventures, and other alliances each year.
- As to doctors – there have been no enforcement actions brought against mergers by physician groups or exclusionary practices by physician groups. As I discussed before, antitrust enforcement in the healthcare industry prior to the Obama administration focused almost entirely on doctors and on the narrow issue of whether these physician groups were sufficiently integrated to jointly negotiate. None of the cases against doctors demonstrated – or even attempted to demonstrate – market power. There has never been a case challenging a physician group merger. In fact, the last case brought that alleged exclusionary conduct by a group of physicians was in 1994. This does not mean this area is free from competitive problems, but to date physician group mergers have not appeared to violate the law.
- As to hospitals – there has been significant consolidation. But much of this consolidation is justifiable and can be procompetitive. No one can dispute there has been significant overcapacity in hospitals and a tremendous need for consolidation. Moreover, scores of hospitals are in a weakened financial state and consolidation is necessary to keep the hospitals operating, serving the community, and preserving jobs. Finally, hospital merger consolidation can lead to improved services and increased quality of care. Not surprisingly even under the renewed enforcement in the Obama Administration the FTC has only challenged three hospital mergers.

Ultimately there must be a prudent balance that recognizes the potential efficiencies of consolidation in a measured fashion and weighs those efficiencies against potential anticompetitive effects.

Enforcement Actions Against Hospitals

Emblematic of this measured approach is the Federal Trade Commission's law suit to enjoin the merger of ProMedica and St. Luke's Hospital in the first and third largest hospitals in Toledo, Ohio. The FTC alleged that the merger will increase concentration and raise prices in acute-care inpatient services and inpatient obstetrical services. However, the complaint also focused on the loss of quality competition, alleging that competition between the two hospitals had "spurred both parties to increase quality of care" and that these elements would be lost after the acquisition. The focus on both price and quality competition show that the FTC recognizes the need to evaluate both price and quality competition. The matter is still pending before an FTC administrative law judge.

Similarly, in 2009, the FTC ordered the Carilion Clinic of Roanoke, VA, to separate from two recently acquired competing outpatient imaging and surgical clinics. Carilion is the dominant hospital system in the market and these outpatient clinics would have posed a significant threat to its dominance in outpatient imaging and surgical services, leading to higher premiums, and the risk of reduced coverage for these needed services. The FTC's willingness to undo an already consummated merger is further demonstration of the administration's commitment to combating concentration in the industry.

Like with health insurers, the Obama administration has ramped up enforcement against anticompetitive conduct by hospitals. Again, antitrust cannot undo concentration but it can prevent practices that create barriers to competition that would threaten that dominance. In *United Regional*, the Department brought a Section 2 case against a Wichita, Texas hospital system that allegedly holds 90% market share in the market for inpatient hospital services, and 65% market share in the market for outpatient surgical services sold to commercial insurers. This was the first case brought by Justice or the FTC against anticompetitive conduct by a provider alleged to have significant market power in more than 17 years. This market power means that United Regional is a "must have" hospital for commercial insurers in the Wichita, Texas region.¹⁸

The complaint alleged that United Regional willfully maintained its monopoly power by employing anticompetitive exclusionary contracts with health insurers. The contracts were relatively simple: health insurers are penalized as much as 27% if they contract with competing hospitals. The contracts defined competitors through geographical limitations, but they all encompassed the primary competing facilities. The DOJ alleged that the monopoly-maintaining contracts had the anticompetitive results of delaying and preventing the expansion of competitors; limiting competition over price; and reduced quality for healthcare services. The DOJ ultimately entered into a consent decree with United Regional that prohibits the hospital

¹⁸ *United States of America and State of Texas v. United Regional Healthcare System*, Complaint, Feb. 25, 2011, available at <http://www.justice.gov/atr/cases/f267600/267651.pdf>

from entering into contracts that improperly inhibit commercial health insurers from contracting with United Regional's competitors.

The Affordable Care Act and Opportunities for Increased Competition

The healthcare reform debate challenged the underpinnings of the antitrust paradigm in healthcare that has generally characterized the past decade. As I discussed earlier, that paradigm was deeply skeptical of integration by healthcare providers, particularly of efforts by physicians to collaborate. Last year's healthcare debate scrutinized this model, however, and shed light on the opposing conception that increased provider integration could actually lead to more efficient, higher quality care. Insufficient integration, the debate clearly demonstrated, contributes to the "silo" problem between the various levels of healthcare delivery and is a central impediment of containing healthcare costs and improving quality.

The Affordable Care Act offers a number of tools to increase competition in healthcare markets. Let me highlight a few. First, in 2014, for example, competition among insurance companies will be spurred as insurers will compete for business on a level and transparent playing field in health insurance exchanges. Second, as Secretary Sebelius has recently stated publicly, the new cooperatives created under the ACA will also help make health insurance markets more competitive. The provisions of the Affordable Care Act aimed at better educating consumers of their options in health insurance further promote competition amongst health insurers. The Consumer Assistance Program of the Center for Consumer Information and Insurance Oversight, for example, is charged with providing the necessary resources for educating consumers about healthcare decisions and will surely foster greater competition among health insurers by creating better-informed consumers. Finally, the ACA promotes the development of ACOs which should spur greater, more integrated and efficient competition.

Under the new health law, physicians, hospitals, and other healthcare providers are encouraged to reduce cost by, among other things forming ACOs. While ACOs involve collaboration among competitors, which has frequently raised antitrust concerns, skepticism of integration provider groups is misguided. Though, as I have mentioned, the agencies appear to have dedicated the vast majority of enforcement resources to the question of integration of physician-negotiating groups, the most difficult issue the agencies must grapple with in the formation of these ACOs is market power, not integration.

What should be the response of enforcers to the concerns of provider market power in the context of ACOs?

First, to the extent the concern is over ACO competition, it is critical that the agencies broaden the standards for integration, in evaluating proposed ACOs. If hospitals dominate some markets, it is even more important that the agencies provide a clear path for physician-sponsored ACOs to be formed. The agencies should permit ACOs to qualify based on clinical integration, not just financial integration. The current integration antitrust standards may create obstacles to physician-sponsored ACOs and that would reduce competitive alternatives in ACO markets.

Second, the FTC should focus its enforcement resources on market power by hospitals and specialized physician groups. The FTC has done an admirable job in reviving hospital-merger enforcement in the past several years. Recent cases, such as the Toledo hospital merger

and the Carilion Clinic case, have demonstrated the importance of antitrust enforcement in preventing the creation or the improper presentation of market power.

The agencies clearly need to focus greater attention in those situations where physicians may possess market power. The DOJ and the FTC have generally overlooked this area—the most recent enforcement action against a group of physicians for exercising market power was 1994. In that case, the FTC challenged joint ventures by two groups of pulmonologists that harmed the home oxygen-equipment market by bringing together more than 60 percent of the pulmonologists who could make referrals for this equipment.¹⁹ This type of referral power by large groups of specialists can raise prices for many procedures. It is interesting to observe that the case was brought under Section 5 of the Federal Trade Commission Act, which declares illegal “unfair methods of competition.” The agencies should use their full range of powers including the FTC’s unique authority under Section 5.

Antitrust enforcement is an important solution but a limited one. The DOJ and the FTC have limited resources. In addition, antitrust enforcement does not break up monopolies or oligopolies that have been legally acquired nor does it restrict much of their exercise of market power. While traditional antitrust enforcement should absolutely remain part of the solution, we must also look to legislative fixes and innovative market reforms like ACOs to address the potential exercise of market power. There are several examples worth considering.

Massachusetts passed a law in August 2010 aimed at controlling health care costs.²⁰ The law requires the Division of Health Care Finance and Policy, or DHCFP, to encourage payers and providers to adopt bundled payment arrangements rather than fee-for-service arrangements. The goal is to implement pilot bundled-payment programs in 2011. The law extends DHCFP’s ability to require providers to submit standardized data about their costs and payments. It requires insurers to file all new rate increases with the commissioner of insurance and the commissioner is directed to disapprove such increases if they are “excessive, inadequate, or unreasonable in relation to the benefits charged.” Perhaps most importantly, it requires that provider networks with 5,000 or more enrollees offer limited-network or tiered-network plans. The base premium for this plan must be at least 12 percent lower than that of the carrier’s “most actuarially similar” plan that does not include such a network. There are also some specific provisions in the law that ensure that the tiered or limited networks will engender cost savings. Taken together, these provisions may make some real impact on containing price increases.

Paul Ginsburg also offers a number of suggestions for decreasing costs as part of his study. He breaks the suggestions down into two categories: a market approach and a regulatory

¹⁹ *In the Matter of Home Oxygen & Medical Equipment Co., et al*, 118 F.T.C. 661 (1994) (challenge under Section 5 to joint venture of 13 competing pulmonologists in California who formed a joint venture involved in the supply of home oxygen and other related medical equipment, which consisted of 60 percent of the pulmonologists in the relevant geographic area. Because the venture included such a high percentage of the pulmonologists in the area, the FTC alleged, it allowed the specialists to gain market power over the provision of oxygen to patients in their homes, and created a barrier against others who might offer that service (i.e., through patient referrals by the owner-pulmonologists and the resulting inability of another oxygen supplier to obtain referrals from pulmonologists), thereby reducing competition and risking higher consumer prices).

²⁰ *An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses*, August 10, 2010, available at <http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288>.

approach. In the market approach, the goal is to provide mechanisms that encourage individuals to obtain lower cost services. The vertical integration of the ACO model provides consumers with an understandable comprehensive cost of care that will then be easier to compare with other provider options. In the regulatory approach, the government may establish a common payment method across public and private payers and set a ceiling on the amount that providers can charge insurers. For example, in Maryland, all-payer rate setting is used for hospitals.

All of these recommendations on potential regulation pose complex issues. It is important to recognize that the ultimate goal of the Affordable Care Act is improved access to improved health care delivery. In assessing the roles of ACOs and potential regulation, there are important tradeoffs to be made.

Recommendations

Ultimately, concerns with health care industry consolidation need to be focused on strong consumer protection and the balanced antitrust enforcement paradigm I have described. Below are some recommendations for building a solid structure for competition and consumer protection enforcement that is supportive of efforts at reform, while protecting competition in healthcare markets.

1. Increase coordination among government health and antitrust agencies. A vast majority of healthcare expenditures are in government programs and maintaining competition in these programs is vital for controlling costs. The DOJ and the FTC need to work with HHS and CMS to ensure that taxpayers are receiving the full benefits of the most efficient, lowest cost services.
2. The Obama administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious, and deceptive conduct by insurers. The structure of the health insurance market is broken and the evidence strongly suggests a pervasive pattern of deceptive and egregious practices. Health insurance markets are extremely concentrated, and the complexity of insurance products and opaque nature of their practices make these markets a fertile medium for anticompetitive and deceptive conduct.
3. Reinvigorated enforcement against anticompetitive conduct by health insurers and providers. The FTC should scrutinize anticompetitive conduct and use its powers under Section 5 of the FTC Act. Section 5 of the FTC Act can attack practices which are not technical violations of the traditional antitrust laws, the Sherman and Clayton Acts. Thus the FTC can use that power under Section 5 to address practices which may not be technical violations of the federal antitrust laws, but still may be harmful to consumers. As I have testified elsewhere, the FTC should begin to use that power under Section 5 to attack a wide range of anticompetitive and egregious practices by health insurers and PBMs.
4. Conduct a retrospective study of health insurer mergers. I and the American Hospital Association have suggested elsewhere that one approach to this issue would be for the FTC or the DOJ to conduct a study of consummated health insurer mergers. One of the significant accomplishments of the Bush administration was a retrospective study of consummated hospital mergers by

the Federal Trade Commission. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical tools for addressing health insurance mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.

5. Recognizing that the insurer does not represent the consumer. Although insurers do help to control cost, they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the consumer interest, but rather exploit the lack of competition, transparency, and the opportunity for deception to maximize profits.
6. Clarify the jurisdiction of the FTC to bring enforcement actions against health insurers. Some may suggest that the FTC lacks jurisdiction over health insurance. I urge Congress to ask the FTC to clarify their position on this issue. Is the claim of no jurisdiction the law or simply an urban legend? As I understand it, there is a limitation in Section 6 of the FTC Act that prevents the FTC from performing studies of the insurance industry without seeking prior Congressional approval. This provision does not prevent the FTC from bringing either competition or consumer protection enforcement actions. There may be arguments that the McCarran-Ferguson Act limits jurisdiction, but that exemption is limited to rate making activity. In addition, some people might argue that the FTC's ability to attack anticompetitive conduct by nonprofit insurance companies might be limited under the FTC Act. The solution to this problem is simple, straightforward and critical. If the FTC lacks jurisdiction in any respect to bring meaningful competition and consumer protection enforcement actions against health insurers, Congress must act immediately to provide that jurisdiction. There is no reason why health insurance should be immunized from the Federal Trade Commission Act.
7. Congress should repeal the McCarran-Ferguson Act, exempting insurers from the full range of federal antitrust laws. Eliminating the exemption will make it clear that the Justice Department can bring antitrust cases and the Federal Trade Commission can bring consumer protection cases against health insurers. Repeal of this exemption would improve competition and is necessary for the type of substantial antitrust enforcement that is long overdue in health insurance markets.²¹

²¹ Testimony of David A. Balto, "Protecting Consumers and Promoting Health Insurance Competition" before the House Judiciary Committee Subcommittee on Courts and Competition Policy on H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009" (October 8, 2009).