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PATIENT PROTECTION AND AFFORDABLE CARE ACT, CONSOLIDATION, AND THE CONSEQUENT IMPACT ON COMPETITION IN HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON
REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

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PATIENT PROTECTION AND AFFORDABLE CARE ACT, CONSOLIDATION, AND THE CONSEQUENT IMPACT ON COMPETITION IN HEALTHCARE

THURSDAY, SEPTEMBER 19, 2013

HOUSE OF REPRESENTATIVES,

SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW

COMMITTEE ON THE JUDICIARY,

Washington, DC.

The Subcommittee met, pursuant to call, at 1:02 p.m., in room 2141, Rayburn Office Building, the Honorable Spencer Bachus (Chairman of the Subcommittee) presiding.

Present: Representatives Bachus, Goodlatte, Marino, Holding, Collins, Smith of Missouri, Cohen, Conyers, DelBene, and Garcia.

Staff present: (Majority) Anthony Grossi, Counsel; Ashley Lewis, Clerk; Justin Sok, Legislative Assistant to Mr. Smith of Missouri; Jon Nabavi, Legislative Director to Mr. Holding; Jaclyn Louis, Legislative Director to Mr. Marino; Jennifer Lackey, Legislative Director to Mr. Collins; and (Minority) James Park, Minority Counsel.

Mr. BACHUS. The Subcommittee on Regulatory Reform, Commercial and Antitrust Law hearing will come to order.

Without objection, the Chair is authorized to declare recesses of the Committee at any time.

Mr. Cohen is engaged in the debate on the floor concerning the SNAP program, and he will arrive in the next few minutes. But he has asked me to go ahead and proceed.

The first order of business is the opening statements by the Members.

Let me welcome everyone to today's hearing on consolidation in the health care marketplace. The Patient Protection and Affordability Act—I am going to refer to it as Obamacare, as it is sometimes commonly known and referred to even in the press for brevity. But its effect or its impact on consolidation and the resulting effects on competition. The cost of health care is an issue that comes up almost on a daily basis in the news and certainly in conversations with my constituents and here on the Hill, especially small business owners.

A way to curb these expenses and address the rising cost of Government entitlement programs like Medicare and Medicaid is to promote a competitive health care marketplace. As Members of the

Judiciary Subcommittee with antitrust oversight, we have the responsibility to ensure that the laws passed by Congress do not produce anticompetitive effects and that our enforcement agencies are properly policing anticompetitive conduct.

Today we will be focusing our oversight on the health care industry and the impact of the passage of the Affordable Care Act on consolidation and competition in the health care marketplace.

Significant consolidation in the industry started around the beginning of the 1990's when there was an industry shift to managed care organizations. Nearly 2 decades later when Obamacare was signed into law, over 80 percent of the hospital markets and over 70 percent of the health insurance markets were considered highly concentrated by the standards used by the Department of Justice and the FTC. And I know some of our witnesses were with the FTC. In other words, Obamacare was enacted in an environment of clear consolidation in the health care industry which actually began to occur long before its passage.

And now not all consolidation is necessarily negative. Consolidation can result in greater efficiencies. In the context of health care, this can translate into a higher quality of care at a lower cost.

However, consolidation can be troubling when it falls into one of two categories. The first is consolidation in a particular market that reaches a level where competition is improperly stifled. The second is consolidation motivated by Government intervention.

Our hearing today will focus on these types of consolidation. It is my belief that Obamacare with its top-down, highly regulatory approach will further accelerate consolidation in the industry. Less competition in this case could mean less patient choice or will mean less patient choice and decisions being made according to Government dictates rather than according to the needs of consumers in the health care marketplace. Broadly speaking, this is a result of provisions in the law that compel the insurance industry to offer a more commoditized product where profits can be achieved only through economies of scale, incentivizing further consolidation activity and the health care services market by increasing regulatory burdens, revising Medicare and Medicaid reimbursement rates, and promoting the formation of consolidated entities commonly referred to as "accountable care organizations."

We have a distinguished panel of witnesses here today that will provide us with testimony concerning the current state of the competitive landscape and how the new health care law has impacted and continues to impact consolidation and competition in the health care industry. And I look forward to hearing their testimony.

And we have people of varying opinions and obviously contrasting opinions, and that is a part of a democracy. So I think by hearing all sides or different sides of an argument, we can form—at least hope to begin to form some opinions as to what the true state of the health care industry is as it relates to consolidation.

Once we recognize other Members who wish to make an opening statement—I know Mr. Conyers is not here. Mr. Goodlatte is not here. Mr. Cohen is not here. So do the gentlemen from Pennsylvania or New York have anything they want to say? Two former

U.S. attorneys with us. Watch what you say. Didn't I say North Carolina? Yes, I did.

Without objection, other Members' opening statements will be made a part of the record.

As I said, we have a very distinguished panel today, and I will begin by first introducing our witnesses and then we will move to the statements of our panelists.

Ms. Pozen is a partner in the antitrust and competition practice group at Skadden, Arps. I am going to read the whole name of the law firm because Skadden, Arps is what we call it. Right? So it is Skadden.

Ms. POZEN. Skadden.

Mr. BACHUS. Skadden. And she is representing the views of the American Hospital Association.

Prior to joining the law firm, she served as Assistant Attorney General at the Department of Justice. During her time at DOJ, she oversaw the antitrust litigation that resulted in injunctions against the proposed purchase by AT&T of T-Mobile and of H&R Block's proposed merger with TaxACT. Ms. Pozen also served as an attorney advisor to FTC Commissioners Dennis Yao and Christine Varney.

She received her B.A. from Connecticut College and her J.D. from Washington University Law School in St. Louis.

The first of our Millers—we have two millers testifying today—is Mr. Joseph Miller. He is the General Counsel of the America's Health Insurance Plans. Prior to joining AHIP, he served in the Antitrust Division of the Department of Justice from 1998 to 2010, including 6 years as Assistant Chief of the Litigation Section. There he oversaw enforcement and competition advocacy in, among other things, health care and insurance markets. Before joining the DOJ, he worked for Collier, Shannon, Rill & Scott as a trial attorney for the FTC.

He received his B.A. from Emory University and his J.D. from George Mason University School of Law. And I guess that means you are conservative. Right? George Mason School of Law?

Professor Barak Richman is an Edgar P. and Elizabeth C. Bartlett Professor of Law and Professor of Business Administration at Duke University School of Law and is on the health sector management faculty at Duke's Business School, Fuqua. His work has been featured in the Columbia Law Review, the University of Pennsylvania Law Review, Law and Social Inquiry, the New England Journal of Medicine, and the Journal of the American Medical Association, and Health Affairs.

Prior to joining Duke Law, Professor Richman clerked for Judge Bruce Selya of the United States Court of Appeals for the First Circuit and served on the staff of the Senate Finance Committee.

Professor Richman has an A.B. magnum cum laude from Brown University and a J.D. magnum cum laude from Harvard Law School and a Ph.D. from the University of California-Berkeley. Did you ease up at Berkeley and just did not study as hard? Was the competition more intense?

Mr. RICHMAN. It took a long time. I had a very patient and supportive wife.

Mr. BACHUS. Mr. Tom Miller is a health policy research and resident fellow at the American Enterprise Institute. He is a prominent frequent speaker and author on health care issues with his work presented to, among others, the American College of Physicians, the American Society of Health Economists, Brigham and Women's Hospital, Harvard Medical School, and the World Health Care Congress Leadership Summit on Medicare.

Prior to joining AEI, he was the Senior Health Economist on the Senate Joint Economic Committee for 4 years and Director of Health Policy Studies at the Cato Institute.

Mr. Miller received his B.A. cum laude from New York University and his J.D. from Duke University. So we have two Duke University graduates.

Professor Tom L. Greaney. And I am pronouncing it right?

Mr. GREANEY. Greaney.

Mr. BACHUS. Greaney. Okay. I stand corrected. I was thinking it was Greaney and then the staff said it was pronounced Greaney.

Mr. GREANEY. It's Irish.

Mr. BACHUS. It's Irish? Okay. You are one of 40 million Irish Americans. Do you know how many people are in Ireland today, by the way? There is a little over 4 million and there are 40 million Irish Americans. Their population has just now gotten back up to the population in the Potato Famine, just in the last few years. Interesting little facts that you all can forget as soon as you leave this hearing.

Let's see. Professor Greaney is a Chester A. Myers Professor of Law and Co-Director of the Center for Health Law Studies at Saint Louis University School of Law, author of "Health Law," one of the leading health care case books, as well as numerous articles on the intersection of antitrust and health law that have been published in, among other places, the New England Journal of Medicine, Antitrust Law Journal, Journal of the American Medical Association, and the Yale Journal of Health Law and Policy.

Prior to joining the Saint Louis University School of Law, he served as Assistant Chief in the Antitrust Division of the Department of Justice.

He received his B.A. magnum cum laude from Wesleyan University and his J.D. from Harvard Law School.

Welcome, Professor.

Mr. David Balto is an antitrust attorney at the Law Offices of David Balto. So you are in charge. Right?

Mr. BALTO. Right.

Mr. BACHUS. He has over 15 years of government antitrust experience as a trial attorney in the Antitrust Division of the Department of Justice and in several senior level positions at the Federal Trade Commission during the Clinton administration, including Policy Director of the Bureau of Competition and Attorney Advisor to FTC Chairman Robert Pitofsky?

Mr. BALTO. Pitofsky.

Mr. BACHUS. They did not teach phonetics. I was taught sight reading. So I blame it on the educational system.

He is also an author of the 1996 DOJ FTC Health Care Antitrust Enforcement Guidelines and served as a liaison on competition issues to the Food and Drug Administration and Congress, advising

several committees on pharmaceutical competition and Hatch-Waxman reform.

He received his B.A. from the University of Minnesota and his J.D. from Northeast University School of Law.

At this time, Mr. Conyers, would you care to make an opening statement?

Mr. CONYERS. Just briefly, sir.

Mr. BACHUS. Okay. Go ahead. The Ranking Member of the full Committee is recognized for an opening statement.

Mr. CONYERS. Thank you very much, Mr. Chairman.

And I welcome, as you have already, the six witnesses that we have. And I consider this a very important hearing in view of the 41 attempts by the conservative Members of the House to repeal it ultimately unsuccessfully.

But for those who care about the Nation's health care system, about the millions of uninsured and under-insured, and about the need to serve all consumers of medical services with affordable prices, today's hearing takes on a special importance. And if we care about unfair trade practices, we should consider the measure in the 111th Congress to repeal McCarran-Ferguson. To me that is an incredibly important consideration, and we need to ensure that more providers and insurers will be able to enter the marketplace through a more vigorous antitrust enforcement. The exchanges also will be of some help.

We need to understand how the Affordable Health Care Act will ensure that consumers will obtain lower prices, better health insurance coverage, and improved quality care.

So I am very pleased to join this discussion and examination.

I noticed that one of our witnesses has written a book about why he opposes the Affordable Health Care Act. As a matter of fact, it is entitled "Why Obamacare is Wrong for America." So I await our witness' discussion of this subject since he has made his position very, very clear to all who are interested in it, as I am.

I want to point out that I have introduced H.R. 99, the Health Insurance Industry Antitrust Enforcement Act, on the very first day of this Congress, which would, in effect, repeal the McCarran-Ferguson exemption for health insurance companies. Why should this industry be able to engage in a lot of anticompetitive conduct when I see no sound justification for this exemption? Some of this conduct sometimes includes price fixing, bid rigging, market allocations.

And the problem is compounded, Members of the Committee, by the fact that even though most of the Nation's health insurance markets are disproportionately dominated by a handful of powerful players, enforcement actions challenging consolidation in the health insurance market were rare until only recently. Many of us know of regions that have only two major insurers, some only one. And so this Administration has breathed new life into the Justice Department and the Federal Trade Commission's action, and even in Michigan, there has been action against Blue Cross Blue Shield of Michigan because of their dominance and conduct in my home State. And there are lawsuits going on in other places.

Now, the marketplaces will foster competition with existing insurers and potentially allow for even new innovators to enter the

market. And so I am hopeful that this discussion this afternoon will shed light on these activities.

And I salute the Chairman of this Committee for bringing a subject of this significance to our attention for examination. I think that it will be a helpful one.

And I yield back the balance of my time.

Mr. BACHUS. I thank the Ranking Member.

Without objection, other Members' opening statements will be made a part of the record.

At this time, I would like to recognize one of our former colleagues, the gentleman from Massachusetts, Mr. Bill Delahunt, who is a good friend of many of us. Bill, why don't you come up here and sit near the front?

Mr. DELAHUNT. I prefer being in the back.

Mr. BACHUS. Do you? Okay. He served on our Commercial and Administrative Law Subcommittee and he was a distinguished Member and I think a great friend of many of us. We have a tremendous amount of respect. I do for you personally. We welcome you back, and we miss you in Congress and what was a rational, reasonable voice.

At this time, we will start with our witnesses, and Ms. Pozen, if you will go first. Basically 5 minutes, but we are not going to adhere. If it is 6 minutes, it is 6 minutes. Whoever wrote the book on why Obamacare—was that Mr. Miller? You can get 8 minutes. [Laughter.]

Mr. THOMAS MILLER. Not long enough. [Laughter.]

Mr. BACHUS. No. I am kidding.

Thank you.

TESTIMONY OF SHARIS A. POZEN, PARTNER, SKADDEN, ARPS, SLATE, MEAGHER & FLOM LLP, REPRESENTING AMERICAN HOSPITAL ASSOCIATION

Ms. POZEN. Well, on behalf of the nearly 5,000 member hospitals and 43,000 individual members of the American Hospital Association, I appreciate the opportunity to speak to the Committee today.

I am Sharis Pozen. As was noted, I am a partner in the Antitrust and Competition Group at Skadden, Arps. I previously served as acting Assistant Attorney General at the Department of Justice, and I also had the privilege of serving at the Federal Trade Commission.

An editorial in Tuesday's Politico, co-authored by the President of the National Business Group on Health, attributed the nearly unprecedented low growth in health care inflation largely to the new models of health care delivery in both the public and private sectors.

There is no question that the health care field is undergoing a period of fundamental transformation in which the very model of health care delivery is being changed in order to improve quality and lower costs. The reasons for such changes are varied, but chief among them——

Mr. BACHUS. Wait. Let's have order on the dais. If we could let the witnesses testify. It is just kind of picking it up.

Ms. POZEN. As I said, there is no question that the health care field is undergoing a period of fundamental transformation in

which the very model of health care delivery is being changed in order to improve quality and lower costs. The reasons for such changes are varied, but chief among them are the expectations by patients, employers, insurers, and government at all levels for higher quality and more efficient health care, in other words, greater value.

Meeting these expectations requires building a continuum of care to replace the current fragmented system. In addition, hospitals are facing enormous pressure to raise capital to invest in new technologies and facility upgrades.

Some degree of consolidation through a variety of means, through mergers and acquisitions or others, is one way chosen by providers to make these goals a reality. It is also why doctors and other caregivers are being added to the hospital family. They are the linchpin of better, more coordinated care.

Providers often choose consolidation as a way to gain enhanced efficiencies in quality, as was noted, because regulatory barriers can keep hospitals and doctors from working closely together unless they are under the same ownership umbrella. Antitrust laws, fraud and abuse policies, and even tax exempt rulings can cause providers to choose consolidation over clinical integration. It is notable that all the Federal agencies that administer these laws needed to provide guidance or waivers to make the Medicare ACO program feasible. But this effort is not extended to commercial organizations yet.

Some pundits decry this changing landscape. These critics, it seems, would like to have it both ways. On the one hand, they blame the current health care system for high costs and inefficient and uncoordinated care. On the other hand, they express alarm over the prospects of hospitals trying to replace the current silos with a better coordinated continuum of care that delivers higher quality care at lower costs.

These criticisms are often at odds with the assessments of professional observers such as Moody's and Standard & Poor's and are too often based on flawed data and possibly out-of-date biases. Moreover, they rarely pause to examine the impact that a concentrated health insurance market currently has on health care prices and quality.

They are also at odds with the data. A recent study conducted for the AHA by the Center for Healthcare Economics and Policy, which was updated today in fact, found that only 12 percent of the Nation's nearly 5,000 hospitals were involved in a merger or acquisition between 2007 and June 2013. And far from being anticompetitive, these activities can have real benefits for the affected patients and communities. Of those hospitals that were involved in these transactions, all but 22 occurred in areas where there were more than five independent hospitals. That means that there are plenty of independent hospitals left following the transaction to maintain a competitive marketplace.

The stories about how the transaction benefited the community are compelling. Nine of the transactions, in fact, involved small hospitals with 50 or fewer beds, the type of hospitals that often struggle without a larger partner to supply essential capital for specialized expertise.

Moreover, mergers and acquisitions are vigorously policed by two Federal and numerous State antitrust authorities. Officials at the antitrust agencies have stated repeatedly that they have been and will remained focused on competition in the health care sector. Transactions that these authorities deem to be anticompetitive in fact have been challenged.

However, despite this activity, hospitals' price growth is at an historic low and is not the main driver of higher health insurance premiums. The growth in health insurance premiums from 2010 to 2011 was more than double that of the underlying health costs, including the costs of hospital services.

The antitrust authorities should continue to pay as much attention to the health insurance industry as it does to the hospital field, and there is no question that the health insurance industry is highly concentrated and is now acquiring hospitals and providers in an effort to replicate the care continuum hospitals are building.

In closing, thank you for the opportunity to testify today. Patients receive significant benefits when caregivers work together to provide more coordinated, more efficient, and higher quality care. We look forward to working with the Subcommittee to forge ahead toward a shared goal: improving the quality of American health care. Thank you.

[The prepared statement of Ms. Pozen follows:]

Prepared Statement of Sharis A. Pozen, Partner, Skadden,Arps, Slate, Meagher & Flom LLP, representing American Hospital Association

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Statement
of the
American Hospital Association
before the
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
of the
Committee on the Judiciary
of the
U.S. House of Representatives

"The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare"

September 19, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement to the Subcommittee on Regulatory Reform, Commercial and Antitrust Law of the Committee on the Judiciary as it examines "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare."

The health care field is undergoing a period of fundamental transformation in which the very model of health care delivery is being changed in order to improve quality and lower costs. The reasons for such change are varied; but chief among them are expectations by patients, employers, insurers and government at all levels for higher quality, more efficient health care – in other words, greater value. Meeting these expectations requires building a continuum of care to replace the current fragmented system of health care. In addition, hospitals are facing enormous pressure to raise capital to invest in new technologies and facility upgrades.

Mergers or acquisitions are often essential to make these goals a reality. That is also why doctors and other caregivers are being added to the hospital family – they are linchpins of better, more coordinated care. One reason: Outdated regulatory barriers can keep hospitals and doctors from working closely together unless they are under the same ownership umbrella.

Some pundits decry the changing landscape. These critics, it seems, would have it both ways. On the one hand, they blame the current health care system for high costs and inefficient and uncoordinated care, among other ills. On the other hand, they express alarm over the prospect of *hospitals* trying to replace the current silos with a better-coordinated continuum of care that delivers higher quality care at a lower cost.

These criticisms are often at odds with the assessments of professional observers, such as Moody's and Standard & Poor's, for example, and are too often based on flawed data and out-of-date biases. Moreover, they rarely pause to examine the impact that a concentrated health insurance market currently has on health care prices and quality, or to note that the health insurance industry is engaged in a round of acquisitions of its own (*e.g.*, doctors and hospitals).

They are also at odds with the data. A recent study conducted for the AHA by the Center for Healthcare Economics and Policy found that only 10 percent of the nation's nearly 5,000 hospitals were involved in a merger or acquisition between 2007 and 2012. The average number of hospitals acquired in a given transaction was small – just one or two. And far from being anti-competitive, these activities had real benefits for the affected patients and communities.

THE FORCES DRIVING REALIGNMENT

From Volume to Value. The hospital field has long recognized the need to build a more coordinated continuum of care, and the benefits that the continuum could have for patients. More than a decade ago in its 2000 report, *To Err is Human: Building a Safer Health System,* the Institute of Medicine (IOM) called for improvements in the way care is delivered and stressed the importance of creating systems that support caregivers and minimize risk of errors. In its subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* the IOM challenged the adequacy and appropriateness of the current health care system to address all components of quality and meet the needs of all Americans. According to the report, a 21st century system should provide care that is "evidence-based, patient-centered, and systems-oriented."

As an outgrowth of those reports, a number of commentators, including the IOM, advocated linking provider payment to provider performance on quality measures because such an approach is "one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes." Numerous pay-for-performance and incentive programs were launched in the private sector and were incorporated into Medicare payment systems for both hospitals and physicians. Those programs were predicated on collaboration through aligning hospital and physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes.

According to a 2012 Moody's report, "[t]he ability to demonstrate lower costs while providing higher quality will be the key driver in government and commercial reimbursement going forward."[1] One estimate is that 6 percent of hospital revenue could be at risk from penalties from government and commercial payers for lack of coordination.

Investment Needed to Drive Improvement. At the same time, the need for capital to build the continuum is also driving hospitals together. Hospitals are faced with unprecedented demands for capital to invest in new technology such as electronic health records – as much as $50 million for a mid-size hospital – implement new modes of delivering care such as telemedicine, and build new and improved facilities. Moody's states that "[a]ccess to capital markets has become more difficult for lower-rated hospitals, driving the need for many to seek a partner."

BARRIERS IMPEDING PROGRESS

Regulatory Hurdles. Mergers and acquisitions are often the preferred way to build the care continuum because of numerous regulatory barriers that prevent providers from working together to deliver care more efficiently. Antitrust laws, outdated fraud and abuse policies and even tax-exempt rulings favor consolidation over clinical integration. It is notable that all of the federal agencies that administer these laws needed to provide guidance or waivers to make the Medicare Accountable Care Organization (ACO) program feasible. However, their coordination ends outside of that narrow program.

As long ago as 2005, an AHA Task Force on Delivery System Fragmentation found that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and Department of Justice (DOJ), to:

> Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements are a significant barrier. Few arrangements can be structured without very significant legal expense.

Despite those calls, and calls from many others, including members of Congress, most of these regulatory barriers remain. As noted, these barriers favor mergers and acquisitions over integration and should be addressed without delay.

CHANGING LANDSCAPE PROVIDING BENEFITS TO PATIENTS AND COMMUNITIES

Much has been written and said about hospital mergers and acquisitions – primarily, that they are anticompetitive and driving up health care costs. But what the facts show is that the overwhelming majority of transactions over the past six years are procompetitive and fully support the twin goals of higher quality and more affordable health care.

The AHA and the Center for Healthcare Economics and Policy (Center) recently released the results of a comprehensive study the Center undertook to determine just how many hospital transactions there have been since 2007 and how many hospitals remained in a local area following those transactions to provide options for patients in need of hospital care.[ii]

Hospital markets are local. Determining the potential competitive impact of any transaction begins by looking for other hospitals in the area. The Center measured the impact of these transactions by Metropolitan Statistical Area, which is a geographical region with a relatively high population density at its core and close economic ties throughout the area. Between 2007 and 2012 only a fraction of the hospital field, 551 hospitals or about 10 percent of community hospitals, have even been involved in a transaction (merger or acquisition).

The transactions themselves have been modest: the average number of hospitals acquired in a transaction was between 1 and 2. Of those hospitals that have been involved in a transaction, *all but 20 have occurred in areas where there were more than five independent hospitals.* That means there were plenty of hospitals left following the transaction to maintain a competitive marketplace.

Looking more closely at hospitals included within this group of 20, the stories about how the transaction benefitted the community are compelling. Nine of the transactions involved small hospitals with 50 or fewer beds; the type of hospitals that often struggle without a larger partner to supply essential capital or specialized expertise.

- One hospital (25 beds) was in bankruptcy when it was acquired.
- Another hospital (34 beds), received a commitment of $10 million in new investment over 10 years.
- One hospital (50 beds) was struggling with excess capacity when it was acquired.
- For two hospitals (25 beds), the acquisitions included promises of new services (*e.g.*, a birthing center, a new information system).
- For another hospital (12 beds), recently altered federal regulations made it difficult to grow or expand and the hospital likely would not have been able to stay open; the transaction was reviewed by the state attorney general.
- For a slightly larger rural hospital (85 beds), the city approved the transaction to "ensure the long-term viability of the community's acute care hospital, long-term care facility and independent living apartments for seniors." Officials specifically noted the challenging regulatory environment facing rural hospitals.
- Another larger hospital (181 beds) was losing money and had laid off 91 employees the year before it was acquired.
- In a transaction that involved two different hospitals being acquired at the same time (and that was cleared by Federal Trade Commission(FTC)), one of those hospitals was owned by a corporation that went out of business shortly after the acquisition and the other was suffering from a deteriorating facility, decreased patient volumes and various financial challenges.

Mergers and acquisitions are vigorously policed by **two** federal and numerous state antitrust authorities. Deals and integrative arrangements that these authorities deemed to be anticompetitive have been challenged. In fact, there has been much more attention paid to the hospital field than to the health insurance industry. The result is that the health insurance industry is highly concentrated and is now acquiring hospitals and providers in an effort to replicate the care continuum hospitals are building.

Despite this activity, hospitals' price growth is at an historic low and **is not the main driver of higher health insurance premiums**. The growth in health insurance premiums from 2010 to 2011 was more than double that of underlying health costs, including the cost of hospital services. An important feature of hospital costs is that two-thirds of those costs are attributable to caring for patients, specifically the wages and benefits paid to caregivers and other essential staff. This is unlike any other part of the health care sector.

The numbers of transactions and the stories behind them demonstrate that mergers and acquisitions are supporting the changing landscape of health care delivery in a positive way for patients and communities.

Lack of Health Plan Scrutiny. While these hospital transactions have been scrutinized, less oversight has been applied to the health insurance market. The American Medical Association annually reports that an abundance of health insurance markets are concentrated,[iii] with negative impact on providers. In May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform.*[iv]

Among the AHA's requests was that the Antitrust Division:

- Undertake a comprehensive study of consummated health plan mergers; and
- Revisit and revise its analytical framework for reviewing health plan mergers and conduct complaints. The areas of scrutiny should include whether:
    - Proposed mergers by plans with pre-existing market power should be viewed as presumptively unlawful;
    - The ability of merged or dominant health plans to price discriminate against certain hospitals poses particular concerns about likely competitive harm;
    - Merged or dominant health plans can wreak competitive harm in ways other than reducing prices below competitive levels, such as adversely affecting the development or adoption of quality protocols or technology tailored to meet the needs of hospitals and the patients they serve; and
    - Mergers of health plans with service areas that technically do not overlap because of license or other agreements still pose a risk of competitive harm and, therefore, should be challenged.

While we are pleased that DOJ has increased its enforcement activities against health plans, continued vigilance, commensurate to that applied to hospitals, is essential to ensure continued progress toward building a new health care continuum.

CONCLUSION

Patients receive significant benefits when caregivers work together to provide more coordinated, more efficient and higher-quality care. That is the path we are on and the one that holds the

greatest promise for not only improving health but fixing the fragmented health care delivery system.

We look forward to working with this subcommittee to forge ahead toward a shared goal: improving the quality of American health care.

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[i] Moody's Investors Service Inc. (2012.) *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*. Accessed at: www.moodys.com.

[ii] Center for Healthcare Economics and Policy (2013). *How Hospital Mergers and Acquisitions Benefit Communities*. Accessed at: http://www.aha.org/content/13/13mergebenefitcommty.pdf.

[iii] American Medical Association. (2012). *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2012 Update*. Accessed at: https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod1170048&navAction=push.

[iv] American Hospital Association. (2009). *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*. Accessed at: www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf.

Mr. BACHUS. Thank you very much.
Mr. Miller?

TESTIMONY OF JOSEPH MILLER, GENERAL COUNSEL, AMERICA'S HEALTH INSURANCE PLANS

Mr. JOSEPH MILLER. Good afternoon, Chairman Bachus and Members of the Subcommittee. I am Joe Miller, General Counsel for America's Health Insurance Plans.

I appreciate this opportunity to testify on issues surrounding competition and consolidation in the U.S. health care system. These issues have far-reaching implications for the cost of health care, quality improvement, consumer choice, and innovative approaches to the delivery of care.

In the health insurance marketplace, competition is helping to drive innovative programs as health plans continually work to make their products more appealing to consumers and employers based on both quality improvements and cost savings. Our members have demonstrated strong leadership in developing and implementing initiatives that provide value to consumers. These include developing performance measures to provide consumers better information about quality and costs to help them make value-based decisions about their medical treatments, providing disease management services to enrollees who stand to benefit the most from proactive interventions, and working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes.

Through these and other strategies, health plans are working to ensure that their enrollees receive high quality health care at competitive prices. Vigorous competition among other participants in the health care system, including hospitals and physician practices, also is crucial to promoting the best interests of consumers.

Consumers benefit when health care providers compete to offer them lower costs, higher quality services, and innovative approaches to delivering care. There are situations in which provider consolidation does not impede these or even enhances these goals. In other situations, however, consolidation substantially reduces competition among providers and leaves consumers with higher costs and diminished quality.

The Federal antitrust agencies have selectively and carefully challenged mergers of hospitals that hold a significant prospect of harm to such consumers. Now, while such challenges represent a relatively small percentage of the total number of hospital mergers, they are of great importance to consumers. Not only do such challenges prevent harm in specific markets, they also deter other anticompetitive transactions.

According to Irving Levin Associates, the number of hospital mergers and acquisitions in the United States has more than doubled from 50 in 2009 to 105 in 2012. Moreover, an analysis by Bates White Economic Consulting found that hospital ownership in 2009 was highly concentrated in more than 80 percent of the 335 areas studied.

Professors Richman and Greaney cite the academic literature in their written statements that demonstrate hospital consolidation can result in consumer harm. I will add to that list two policy stud-

ies to bring to your attention. A June 2012 Robert Wood Johnson study found that increases in hospital market concentration led to increases in the price of hospital care and that when hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent. Second, a September 2013 research brief by the Center for Studying Health System Change reported that increases in provider prices explain most, if not all, of the increase in premiums in recent years.

Now, through the ACA implementation process, AHIP has emphasized that affordability must be a central goal in health reform and addressing provider market issues is an important part of achieving this goal. Promoting competition and halting harmful consolidation in provider markets are critically important steps toward increasing affordability. With that in mind, our written testimony offers the following recommendations.

We urge the Federal Trade Commission and the Department of Justice to continue to be vigilant in identifying hospital mergers that would harm consumers by concentrating market power in a way that diminishes competition.

We further encourage the agencies to examine the increasing acquisition of physician practices by hospitals and the potential competitive implications of such acquisitions.

We urge the Committee and other policymakers to closely monitor the Medicare shared savings program and ensure it is operating under a regulatory framework that promotes choice and competition and does not allow accountable care organizations to accumulate market power that leads to higher costs.

Third, we encourage the Federal agencies, HHS, and other agencies to take steps to help consumers obtain useful, actionable information about provider cost and quality.

Thank you, Mr. Chairman, for the opportunity to testify and I look forward to your questions.

[The prepared statement of Mr. Joseph Miller follows:]

Competition and Consolidation in the U.S. Health Care System

by

Joe Miller
General Counsel
America's Health Insurance Plans

for the
House Judiciary Committee
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

September 19, 2013

I. Introduction

Chairman Bachus, Ranking Member Cohen, and members of the subcommittee, I am Joe Miller, General Counsel for America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Before joining AHIP in 2010, I worked at the Antitrust Division of the U.S. Department of Justice for 12 years. My last job at the Antitrust Division was as Assistant Chief of the Litigation I Section, with jurisdiction over health care and health insurance. I have also worked in private practice, and began my legal career as a staff attorney for the Federal Trade Commission.

We appreciate this opportunity to testify on issues surrounding competition and consolidation in the U.S. health care system. These issues have far-reaching implications for the cost of health care, quality improvement, consumer choice, and innovative approaches to the delivery of care. We applaud the committee for holding this hearing to call attention to these important issues.

Our testimony today focuses on the following topics:

- The importance of ensuring vigorous competition in the health care system;
- The harmful impact of anticompetitive consolidation among hospitals and other health care providers;
- The ability of hospitals to pursue innovation and quality without harmful consolidation; and
- Issues for policymakers to consider in the new regulatory environment created by the Affordable Care Act (ACA).

II. The Importance of Ensuring Vigorous Competition in the U.S. Health Care System

A highly competitive health care system is the best way to achieve innovative, high quality, affordable health care for all Americans. Vigorous competition creates incentives for all stakeholders to increase efficiency and hold down costs for consumers.

In the health insurance marketplace, competition is helping to drive innovative programs as health plans continually work to make their products more appealing to consumers and employers based on both quality improvements and cost savings. Our members, while operating in competitive markets, have demonstrated strong leadership in developing and implementing initiatives through which they are:

- developing performance measures to provide consumers better information about quality and costs to help them make value-based decisions about their medical treatments and how their health care dollars are spent;
- rewarding quality and promoting evidence-based health care through payment reforms;
- providing disease management services to enrollees who stand to benefit the most from pro-active interventions;
- working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- providing incentives to promote the use of decision-support tools and health information technology;
- providing quality improvement reports for physicians to monitor their progress in managing disease;

- improving the flow of information between clinicians and plans through administrative simplifications;
- offering personalized risk assessments and wellness programs;
- encouraging electronic prescribing and consumer safety alerts; and
- providing peer-to-peer comparisons to demonstrate the appropriate use of health care services across specialists.

Through these and other strategies, health plans are working hard to ensure that their enrollees receive high quality health care at competitive prices. Vigorous competition among other participants in the health care system, including hospitals and physician practices, also is crucial to promoting a fair system that serves the best interests of consumers. Such competition – which is stifled in a growing number of markets by provider consolidation – is needed not only to create incentives for providers to control costs and increase efficiency, but also to promote quality improvements and innovation.

III. The Harmful Impact of Anticompetitive Consolidation Among Hospitals and Other Health Care Providers

Provider-related costs are a significant portion of total medical costs, and the growth in such costs has had an important, and detrimental, effect on consumers. Consumers benefit when health care providers compete to offer them lower costs, higher quality services, and innovative approaches to delivering care. There are situations in which provider consolidation does not impede these benefits or even enhances them. In other situations, however, consolidation diminishes competition among providers and leaves consumers with higher costs, diminished quality, and a reduced prospect of innovation or improvement. The federal antitrust agencies have selectively and carefully challenged mergers of hospitals that hold a significant prospect of such harm to consumers. While such challenges represent a relatively small percentage of the total number of hospital mergers, they are of great importance to consumers. Not only do such

challenges, and the investigations that preceded them, prevent harm in specific markets, they also deter other anticompetitive transactions through a sentinel effect.

According to Irving Levin Associates[1], a health care research firm, the number of hospital mergers and acquisitions in the United States more than doubled from 50 in 2009 to 105 in 2012. Moreover, an analysis of provider consolidation by Bates White Economic Consulting[2] found that hospital ownership in 2009 was "highly concentrated" in more than 80 percent of the 335 areas studied. Numerous research findings demonstrate that this consolidation in the hospital industry is resulting in higher health care costs for consumers and employers:

- A June 2012 study published by the Robert Wood Johnson Foundation (RWJF)[3] found that "increases in hospital market concentration lead to increases in the price of hospital care," and that "when hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent." This study further cautions that "physician-hospital consolidation has not led to either improved quality or reduced costs" and, additionally, points out that consolidation "is often motivated by a desire to enhance bargaining power by reducing competition." An earlier RWJF research project[4], focusing on hospital consolidation in the 1990s, stated: "Studies that examine consolidation among hospitals that are geographically close to one another consistently find that consolidation leads to price increases of 40 percent or more."

- An article published in June 2011 by the *American Journal of Managed Care*[5] found that "hospitals in concentrated markets were able to charge higher prices to commercial insurers than otherwise-similar hospitals in competitive markets."

- An issue brief published in July 2011 by the National Institute for Health Care Management Foundation[6] found that one of the factors contributing to higher prices is "ongoing provider

[1] New Laws and Rising Costs Create a Surge of Supersizing Hospitals, *New York Times*, August 12, 2013
[2] Market concentration of hospitals, Bates White Economic Consulting, Cory Capps, PhD, David Dranove, PhD, June 2011
[3] The impact of hospital consolidation–Update, Martin Gaynor, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, June 2012
[4] How has hospital consolidation affected the price and quality of health care?, William B. Vogt, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, February 2006
[5] Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology, James C. Robinson, PhD, *American Journal of Managed Care*, June 24, 2011

consolidation and enhanced negotiating strength vis-à-vis insurers, resulting in an ability to extract higher payment rates from insurers."

- Paul Ginsburg and Robert Berenson, in an article published in the February 2010 edition of *Health Affairs*[7], stated that "providers' growing market power to negotiate higher payment rates from private insurers is the 'elephant in the room' that is rarely mentioned."

- The Massachusetts Center for Health Information and Analysis[8] recently released its "2013 Annual Report on the Massachusetts Health Care Market." In a discussion about the impact of provider consolidation, the report notes that the highest priced 25 percent of providers in Massachusetts received over 50 percent of commercial payments made to acute hospitals and physician groups in 2012. A *Boston Globe* article[9] pointed out that the report's findings show that as hospitals and provider groups consolidate, "larger groups often have the leverage to demand higher prices from insurers."

- A September 2013 research brief by the Center for Studying Health System Change[10] reported that "it is clear that provider market power is key in price negotiations and that certain hospitals and physician groups, known as 'must-haves,' can extract prices much higher than nearby competitors." This study also concludes that "increases in provider prices explain most if not all of the increase in premiums" in recent years.

More recently, a great deal of provider consolidation has been occurring at the so-called "vertical" level. In such situations, hospitals employ, acquire, or effectively control previously independent physicians or physician practices. Again, the effects of such consolidation will depend upon the specific facts and circumstances in particular markets. Some of this consolidation, however, holds the prospect of harm to consumers similar to that which results when previously competing hospitals merge with each other. For example, if such vertical integration reduces competition among hospitals because the relevant physicians will now only

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[6] Understanding U.S. Health Care Spending, National Institute for Health Care Management Foundation, July 2011
[7] Unchecked Provider Clout In California Foreshadows Challenges To Health Reform, *Health Affairs*, February 2010
[8] 2013 Annual Report on the Massachusetts Health Care Market, Massachusetts Center for Health Information and Analysis, August 2013
[9] Partners hospitals, doctors top health-payment list, *The Boston Globe*, August 14, 2013
[10] High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power, Center for Studying Health System Change, September 2013

refer to one hospital, consumers may suffer harm. Similarly, if previously competing physicians are consolidated so that there is no, or less, competition among these physicians, consumers will be harmed. While this is an area in which there is less of an enforcement history, we are pleased that the Department of Justice and the Federal Trade Commission appear to be focusing on these issues as well. We encourage their vigilant inquiries into this area and, where appropriate, their challenge of such consolidation.

IV. Innovation and Quality Are Possible Without Harmful Consolidation

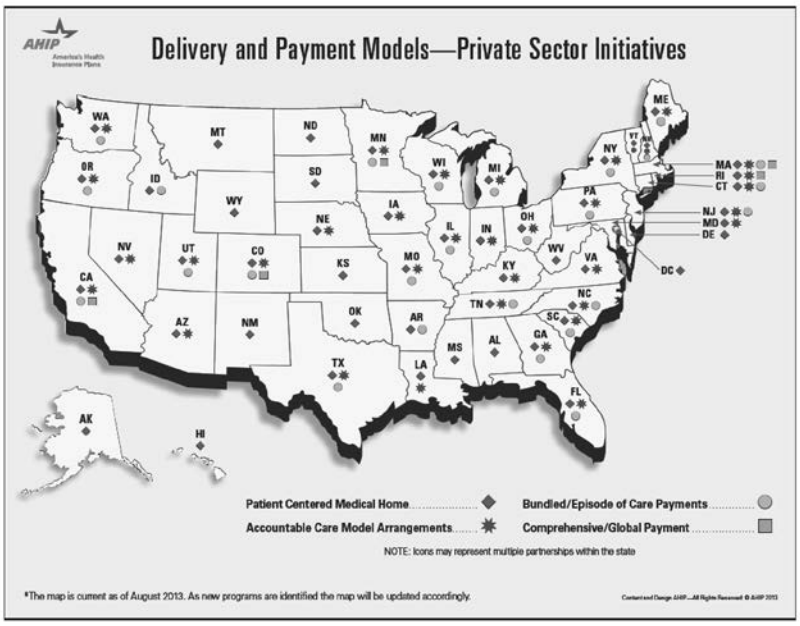
Hospitals seeking to pursue the goals of health reform – higher quality, more efficient care – can achieve these goals without undertaking anticompetitive consolidation. Through the appropriate use of technology and care coordination strategies with partners, hospitals can address health care quality without the harmful effects of consolidation that limits competition.

As we discussed above, health plans and providers have engaged in a wide range of collaborative efforts to improve the quality and efficiency of health care delivery – and these efforts have succeeded without anticompetitive hospital consolidation. In fact, it is likely that such consolidation would have the opposite impact on quality improvement efforts. Just as anticompetitive consolidation has been recognized to have a chilling effect on innovation in many other markets, such consolidation among hospitals is likely to reduce innovative collaborations between health plans and providers. This would be an unfortunate outcome for consumers who might otherwise benefit from the improvements in quality and efficiency generated by these innovative collaborations.

Indeed, many of the health plan initiatives noted above involve health plans partnering with providers to improve quality and lower costs in a manner that does not depend upon anticompetitive provider consolidation (see map below). For example, health plans have been leaders in the adoption of patient-centered medical homes, which attempt to replace episodic care with a sustained relationship between patient and physician.[11] Similarly, health plans have been strong partners in many accountable care organizations, with promising early results in reducing

[11] AHIP Press Release, AHIP Board of Directors Releases Principles on Patient-Centered Medical Home, June 25, 2008

preventable readmissions and total inpatient hospital days.[12] The range of such efforts is vast, beginning with the point of contact with the patient and extending all the way to the "back office" interactions between plans and providers. For example, in Ohio, health plans sponsored an information technology initiative to improve the efficiency of transactions between plans and physicians by providing a one-stop service in electronic transactions for physicians.[13]



Such initiatives not only are consistent with provider competition, but often they rely upon it. The false choice – that we can have either competition or innovation, but not both – should be rejected. Instead, by protecting competition in provider markets, authorities will help quality improvement initiatives to flourish in a variety of forms, with the benefits flowing to consumers as plans and providers work together to address costs and quality.

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[12] Early Lessons From Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers, Aparna Higgins, et al., *Health Affairs*, September 2011

[13] AHIP Press Release, Health Plans Collaborate on Landmark Initiative to Reduce Time, Expense for Physician Office Practice "Paperwork", October 5, 2009

V. Issues for Policymakers to Consider in the New Regulatory Environment Created by the Affordable Care Act

On October 1, less than two weeks from today, health insurance Exchanges across the nation will begin open enrollment for new coverage options that will go into effect on January 1, 2014 under the ACA. We believe that Exchanges can be vehicles that deliver important benefits to consumers, and below we offer a number of suggestions for increasing the likelihood and impact of such benefits.

Our members are strongly committed to offering high quality, affordable health insurance plans under the framework established by the new health reform law. The ways in which they offer such plans vary, but one common theme is that they consistently are seeking to increase affordability and quality. They recognize, though, that this cannot be done without addressing the issue of provider market concentration. Throughout the ACA implementation process, we repeatedly have emphasized that affordability must be a central goal in the health reform process and that addressing provider market issues is an important part of achieving this goal. Promoting competition and halting harmful consolidation in provider markets are critically important steps in making progress toward increased affordability.

Enforcement of Antitrust Laws by FTC and DOJ

The Federal Trade Commission (FTC) and the Department of Justice (DOJ), which have authority to enforce federal antitrust laws, play an important role in challenging anticompetitive behavior in the marketplace. This includes investigating and challenging specific cases of provider consolidation that threaten to stifle competition, increase costs, reduce choices, and undermine quality for consumers and employers. AHIP has supported such agency challenges in the past, including an amicus brief[14] we filed in November 2012 supporting the FTC in its challenge of a merger involving two hospitals in Toledo, Ohio.

[14] Amicus Brief filed by AHIP in U.S. Court of Appeals for the Sixth Circuit with respect to ProMedica Health System, Inc. v. Federal Trade Commission, November 21, 2012

We appreciate the FTC and DOJ's commitment to preserving and promoting competition in health care markets. In testimony[15] submitted for an April 2013 hearing in the Senate Judiciary Committee, the FTC expressed concern about anticompetitive mergers among hospitals, other health care providers, and pharmaceutical manufacturers, cautioning that such mergers can increase health care prices for consumers. We urge the FTC and DOJ to continue to be vigilant in identifying hospital mergers that would harm consumers by concentrating market power in a way that diminishes competition. We further encourage the agencies to examine the increasing acquisition of physician practices by hospitals and the potential competitive implications of such acquisitions, both in specific instances and more generally. Dealing with existing market power, as opposed to new transactions that create it, is a more complicated issue for the antitrust agencies. We encourage them, though, to look both back as well as forwards to identify lessons from past consolidation and inform the dialogue about ways to address its harmful effects. Finally, we also urge Congress to ensure that the agencies have sufficient resources to investigate and challenge hospital and other provider consolidation that does not serve the best interests of the American people.

Regulatory Framework for Accountable Care Organizations

Building upon the success of accountable care organizations (ACOs) that were pioneered in the private sector, the ACA establishes a role for ACOs in the new Medicare Shared Savings Program (MSSP). Under this program, the Department of Health and Human Services (HHS) is contracting with ACOs to assume responsibility for improving quality of care, coordinating care across providers, and reducing the cost of care for certain Medicare beneficiaries. If cost and quality targets are met, ACOs will receive a portion of any savings realized by the Medicare program. As implementation of the MSSP continues, it is important for policymakers to closely monitor this program and ensure that it is operating under a regulatory framework that promotes choice and competition and does not allow ACOs to accumulate market power that leads to higher costs for consumers.

Specifically, we look forward to learning what the agencies have learned from the provision by HHS of aggregated claims data on allowed charges and all fee-for-service payments for all

[15] Testimony on "Oversight of the Enforcement of the Antitrust Laws," Edith Ramirez, Chairwoman of the Federal Trade Commission, April 16, 2013

ACOs in the MSSP. We support the role of many ACOs as a route to improving the care delivered to patients, but we share the FTC and DOJ's caution[16] that "under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality care." We are pleased that the FTC and DOJ will be given information that will be helpful in addressing this concern, and we look forward to the availability of further information that will help policymakers understand what has happened to date and how to reduce the risk of competitive harm in the future.

Transparency on Provider Cost and Quality

Along the same lines, we encourage the federal antitrust agencies, HHS, and other agencies with access to or oversight related to information on provider cost and quality to take steps to help consumers obtain useful, actionable information. Increasingly, consumers are using information to make decisions about their care. These include select network products, reference pricing, and tiering, among others. These products depend upon consumers having access to actionable information and being empowered to use it.

VI. Conclusion

Thank you for considering our perspectives on these important issues. We appreciate this opportunity to testify about the important role of provider competition, and enforcement that protects such competition, in addressing health care costs. We look forward to continuing to work with the committee and the antitrust agencies to promote and preserve competition with the goal of further expanding access to high quality, affordable health care.

[16] Federal Trade Commission, Department of Justice Issue Final Statement of Antitrust Policy Enforcement Regarding Accountable Care Organizations, October 20, 2011

Mr. BACHUS. Thank you, Mr. Miller.

Professor Richman?

TESTIMONY OF BARAK D. RICHMAN, EDGAR P. AND ELIZABETH C. BARTLETT PROFESSOR OF LAW AND BUSINESS ADMINISTRATION, DUKE UNIVERSITY

Mr. RICHMAN. Thank you, Mr. Chairman and Members of the Committee. It is an honor to testify before you on a topic that is extraordinarily important both to our Nation's physiological health and also our Nation's long-term fiscal health.

Latest statistics reveal that the United States spends nearly 18 percent of its gross domestic product on health care services. This is nearly twice the average for OECD nations and far more than number two, which spends less than 12 percent. Viewed another way, the United States in purchase-adjusted dollars spends more than two and a half times the OECD average per capita on health care and more than one and a half times the second largest spender. Yet, in spite of our leadership in health care spending, we are safely in the bottom half of OECD nations on most measures of health care outcomes.

We are spending too much and getting too little in return, and the Nation simply is on an unsustainable trajectory. All discussions about health care policy should begin with the recognition that curbing health care spending needs to be among our Nation's highest priorities. The cost of private health insurance is bankrupting companies and families alike, and the cost of public health care programs are putting unmanageable burdens on both the Federal and State budgets.

Many studies suggest that the cost of health care is unsustainable not because we consume too much health care, but because we pay too much for the health care that we do consume. In other words, as one study put it famously, "It's the prices, stupid." And one of the most severe contributors to the rise of health care prices has been the alarming rise in market power by health care providers.

The past several decades have witnessed extraordinary consolidation in local hospital markets, with a particularly aggressive merger wave occurring in the 1990's. By 1995, the merger and acquisition activity was nine times the level at the start of the decade, and by 2003, almost 90 percent of Americans living in the Nation's larger MSA's faced highly concentrated markets. This wave of hospital consolidation alone was responsible for sharp price increases, including price increases of 40 percent when merging hospitals were closely located.

There is also evidence that hospital consolidation leads to worse outcomes. Another important studied showed this with the clever title "Death by Market Power." One of the authors, by the way, is now the Chief Economist at the Federal Trade Commission, and the taxpayers should be very, very happy that he, Martin Gaynor, is now working for them and their consumer interests.

Even after this merger wave in the 1990's prompted alarm, a second merger wave starting in 2006 significantly increased the hospital concentration in 30 MSA's and the vast majority of Americans are now subject to monopoly power in their local hospital markets.

Hospitals and hospital networks did not achieve this market dominance through superior skill, foresight, and industry, which would be unobjectionable under the antitrust laws. This is not the free market at work. To the contrary, this consolidation occurred because of mergers and acquisitions, and permitting hospital mergers to achieve such remarkable levels of consolidation represents a major failure of our antitrust policy. There is plenty of blame to share—both Democratic and Republican administrations, Congress, the executive, and the courts. But we are now in a position where we must cope with hospital monopolists. In other words, we not only must resist additional consolidation that creates greater market power, but we must develop policy tools that stem the harm that current hospital monopolists are in a position to inflict.

My testimony is divided into three parts. The first briefly reviews some failures in antitrust policy that permitted hospital consolidations with a focus on court decisions in the 1990's. I submit that part of my testimony for the record saying now just that for too long there was a widely held perception that hospitals and especially nonprofit hospitals, unlike all other economic entities, did not reflect economic harm when possessing market power. Research has thoroughly refuted this belief, but for too long hospitals tended to enjoy selective scrutiny under the antitrust laws. The courts' inability over time to apply antitrust law rigorously to the big business of health care and the FTC's failure in convincing them to do so and Congress' failure in instructing them to do so is one important reason why many health care markets are now dominated by firms with alarming pricing power.

The second part of my testimony explains why hospital and health care provider monopoly power is especially costly, even more costly to American consumers than what one might call a typical monopolist. This discussion I also submit for the record saying now only briefly that it is the combination of monopoly power with health insurance that magnifies the effect of provider market power. Health insurance enables a monopolist of a covered service to charge substantially more than the textbook monopoly price, thereby earning even more than the usual monopoly profit. The magnitude of the monopoly plus insurance distortion contributes severely to both excess health care spending and the misallocation of health care dollars.

The third part of my testimony discusses available policy instruments to protect health care consumers against current and growing hospital monopolists. I turn very briefly in some detail to this third part.

Because most hospital monopolists are already highly concentrated, we need a new antitrust agenda. A first order of business would be to fastidiously prevent the formation of new provider monopolies. Because health care providers continue to seek opportunities to consolidate, either through the recent wave of forming accountable care organizations or through alternative means, there remain several fronts available for policymakers to wage an antitrust battle.

A second order of business might be to revisit some already consummated hospital mergers. Retrospective mergers have the additional cost of unscrambling the eggs, but they are worth consid-

ering for mergers that have inflicted significant economic harm. Alternative conduct remedies should be considered as well.

But in addition to prohibiting new mergers and revisiting old ones, an array of other enforcement policies can target monopolists behaving badly, those trying either to expand their monopoly into currently competitive markets or to foreclose their markets to possible entrants. Thus, several fronts remain available for policymakers seeking to restore competition to health care markets. A new antitrust agenda begins with recognizing the extraordinary costs of the health care provider monopolies and continues with aggressive and creative anti-monopoly interventions.

[The prepared statement of Mr. Richman follows:]

"The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare"

Subcommittee on Regulatory Reform, Commercial and Antitrust Law
Committee on the Judiciary
United States House of Representatives

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* Many of the ideas expressed herein are derived from scholarship coauthored with Clark C. Havighurst.

I. Introduction

Thank you Mr. Chairman and members of the committee. It is an honor to testify before you on a topic that is extraordinarily important to our nation's long-term fiscal health.

Latest statistics reveal that the United States spends nearly 18% of its Gross Domestic Product on health care services. This is nearly twice the average for OECD nations and far more than #2, which spends less than 12%. The US, in purchase-adjusted dollars, spends more than two-and-a-half times the OECD average per capita on health care and more than one-and-a-half times the second largest spender. In spite of our leadership in healthcare spending, we are safely in the bottom half of OECD nations on any measure of health care outcomes.

We are spending too much and getting too little in return, and are simply on an unsustainable trajectory. All discussions about national healthcare policy should begin with the recognition that curbing healthcare spending needs to be among our highest national priorities. The cost of private health insurance is bankrupting companies and families alike, and the cost of public healthcare programs are putting unmanageable burdens on the federal and state budgets.

Many studies suggest that the cost of healthcare is unsustainable not because we consume too much healthcare, but because we pay too much for the healthcare that we do consume. In other words, as one study put it famously, "It's the Prices,

Stupid."[1] And one of the most severe contributors to the rise of health care prices has been the alarming rise in market power by healthcare providers.

The past several decades have witnessed extraordinary consolidation in local hospital markets, with a particularly aggressive merger wave occurring in the 1990s. By 1995, merger and acquisition activity was nine times its level at the start of the decade, and by 2003, almost ninety percent of Americans living in the nation's larger MSAs faced highly concentrated markets.[2] This wave of hospital consolidation alone was responsible for sharp price increases, including price increases of 40% when merging hospitals were closely located.[3] Even after this merger wave in the 1990s prompted alarm, a second merger wave from 2006 to 2009 significantly increased the hospital concentration in 30 MSAs, and the vast majority of Americans are now subject to monopoly power in their local hospital markets.[4]

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[1] Gerard F. Anderson et al., It's the Prices, Stupid: Why the United States Is So Different from Other Countries, HEALTH AFF., May-June 2003, at 89.
[2] William B. Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON (2006); CLAUDIA H. WILLIAMS ET AL., ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (2006), *available at* www.rwjf.org/files/research/no9policybrief.pdf
[3] Id. For surveys of how hospital consolidations have increased hospital prices, see Gloria
J. Bazzoli et al., *Hospital Reorganization and Restructuring Achieved Through Merger*, 27 HEALTH CARE MGMT. REV. 7 (2002); Martin Gaynor, *Competition and Quality in Health Care Markets*, 2 FOUNDS. & TRENDS IN MICROECON. 441 (2006); *see also* WILLIAM B. VOGT, NAT'L INST. FOR HEALTH CARE MGMT. FOUND., HOSPITAL MARKET CONSOLIDATION: TRENDS AND CONSEQUENCES (2009), *available at* http://nihcm.org/pdf/EV-Vogt_FINAL.pdf (documenting the extent of provider market concentration among hospitals & other providers).
[4] Cory Capps & David Dranove, Market Concentration of Hospitals (June 2011), *available at: http://www.ahipcoverage.com/wp-content/uploads/2011/10/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf*

Hospitals and hospital networks did not achieve this market dominance through "superior skill, foresight, and industry,"[5] which would be uncontroversial under the antitrust laws. To the contrary, this consolidation occurred because of mergers and acquisitions, and permitting hospital markets to achieve such remarkable levels of consolidation represents a major failure of our antitrust policy. There is plenty of blame to share – both Democratic and Republican Administrations; Congress, the Executive, and the Courts – but we are now in a position where we must cope with hospital monopolists. In other words, we not only must resist any additional consolidation that creates greater market power, but we must develop policy tools that stem the harm that current hospital monopolists are in a position to inflict.

My testimony is divided into three parts. The first briefly reviews some of the failures of antitrust policy that permitted hospital consolidations, with a focus on court decisions in the 1990s. The second part explains why hospital and healthcare provider monopoly power is especially costly, even more costly to American consumers than what one might call a "typical" monopolist. The third part, discusses available policy instruments to protect healthcare consumers against current and growing hospital monopolists. Of particular interest is monitoring the unfurling of Accountable Care Organizations ("ACOs"), which are encouraged by the Patient Protection and Affordable Care Act ("ACA") and, though aiming to address

[5] *United States v. Aluminum Co. of America*, 148 F.2d 416, 430 (2d Cir. 1945) (Hand, J.) ("The successful competitor, having been urged to compete, must not be turned upon when he wins.")

important failures in coordinating care, pose a serious danger to creating additional provider market power.

II. Explaining Past Failures in Antitrust Policy

Ever since the antitrust laws were first applied systematically in the health care sector in the mid-1970s, some judges and commentators have resisted giving the statutory policy of fostering competition its due effect in health care settings.[6] Between 1995 and 2000, for example, antitrust enforcers encountered judicial resistance when challenging mergers of nonprofit hospitals, suffering a six-case

[6] For cases in which the Supreme Court found it necessary to overrule lower courts' attempts to infer special antitrust exemptions or craft softer antitrust rules for health care providers, see National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981) (rejecting implied exemption for market-allocation agreements brokered by health planning agencies created under federal statute); Patrick v. Burget, 486 U.S. 94 (1988) (rejecting state legislature's encouragement of physician peer review in hospitals as a basis for exempting abuses from federal antitrust remedies); Summit Health v. Pinhas, 500 U.S. 322 (1991) (easing standard for establishing potential effect of hospital medical staff decisions on interstate commerce); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (treating physicians' collective agreements on maximum prices as unlawful because claim of procompetitive effects was facially unconvincing); FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986) (upholding adequacy of evidence to support FTC finding that dentists' agreement to deny insurers access to patients' x-rays was anticompetitive, not procompetitive). But see California Dental Ass'n v. FTC, 526 U.S. 756 (1999) (raising FTC's burden of proof in finding anticompetitive collective action by health professionals). The latter decision is critically examined in Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL. POL'Y & L. 939, 949-53 (2001). The antitrust movement in health care was triggered in part by the Supreme Court's rejection in 1975 of general antitrust immunity for the so-called "learned professions." Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). *See generally* CARL F. AMERINGER, THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION (2008).

losing streak in such cases in the federal courts.[7] Although most of those pro-merger decisions ostensibly turned on findings of fact (mostly in identifying a geographic market in which to estimate the merger's probable effects on competition), those findings were often so arbitrary as to signify judicial skepticism about the wisdom of applying antitrust law rigorously in hospital markets.[8] Even as nonprofit hospitals are the primary provider of the nation's hospital care—responsible for 73% of admissions, 76% of outpatient visits, and 75% of hospital expenditures—they tended to enjoy selective scrutiny under the antitrust laws. Implicitly, and often explicitly, the judges seemed to harbor a belief that nonprofit hospitals either would not exercise or would put to good use any market power they might possess.[9]

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[7] U.S. FED. TRADE COMM'N AND U.S. DEPT. OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION ch. 4, at 1-2 n. 7 (2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.htm (accessed 13 May 2009) [hereinafter DOSE OF COMPETITION].

[8] For discussions of these cases and of the general ambivalence towards competition in health care markets, *see* Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007); Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gasses? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497 (2006); Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191 (1997).

[9] The district judge in FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), was especially unambiguous in championing nonprofit hospitals as benign monopolists:

> Permitting defendant hospitals to achieve the efficiencies of scale that would clearly result from the proposed merger would enable the board of directors of the combined entity to continue the quest for establishment of world-class health facilities in West Michigan, a course the Court finds clearly and unequivocally would ultimately be in the best interests of the consuming public as a whole.

Id. at 1302. Likewise, the judge revealed a hostility to price competition between hospitals, remarking that "[i]n the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars." Id. The

The courts' inability over time to apply antitrust law rigorously in the big business that health care—and the FTC's failure in convincing them to do so, and Congress' failure in instructing them to do so—is one important reason why many health care markets are now dominated by firms with alarming pricing power.[10] Fortunately, the government has more recently won back some of the legal ground it lost.

A. Dispelling the Myth that Nonprofit Hospitals Do Not Exercise Pricing Power

In 2007, the Federal Trade Commission (FTC), in a case challenging a merger of nonprofit hospitals on Chicago's North Shore, found convincing proof that, following the merger, the new entity had substantially raised prices to managed-care organizations.[11] The case was unusual because, rather than intervening to stop the acquisition when it was first proposed, the Commission initiated its challenge four years after the merger was consummated. Bringing the case at that stage

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Butterworth court was not alone in its predilections. A Missouri judge, reviewing a hospital merger challenged by the FTC, remarked to the federal agency, "I don't think you've got any business being in here. . . . It looks to me like Washington, D.C. once again thinks they know better what's going on in southwest Missouri. I think they ought to stay in D.C." FTC v. Freeman Hosp., 69 F.3d 260, 263 (8th Cir. 1995) (quoting district court oral hearing).

[10] For surveys of how hospital consolidations have increased hospital prices, *see* G.B. Bazzoli, et al., "Hospital Reorganization and Restructuring Achieved through Merger," 27 HEALTH CARE MANAGEMENT REV. 7 (2002); Martin Gaynor, *Competition and Quality in Health Care Markets*, 2 FOUNDATIONS AND TRENDS IN MICROECONOMICS 441 (2006); William B. Vogt, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, THE SYNTHESIS PROJECT, at 9 (2006). *See also* See William B. Vogt, Hospital Market Consolidation: Trends and Consequences, EXPERT VOICES, NIHCM Foundation, *available at:* http://nihcm.org/pdf/EV-Vogt FINAL.pdf (documenting the extent of provider market concentration among hospitals & other providers).

[11] In re Evanston Northwestern Healthcare Corp., 2007 WL 2286195 (F.T.C. 2007).

accomplished two things: First, it made it unnecessary for the Commission to seek a preliminary injunction against the merger in federal court – where antitrust enforcers had lost the six previous cases. Second, challenging a completed merger gave the Commission's staff an opportunity to demonstrate in fact, and not just in theory, that nonprofit hospitals gaining new market power will use it to increase prices. The direct proof obtained in the *Evanston Northwestern* case makes it unlikely that future federal courts will allow the consummation of mergers of nonprofit hospitals under the illusion that such mergers do not have the usual anti-competitive effects.

The FTC's findings in *Evanston Northwestern* also discredited expert economic testimony that one court had cited prominently in approving a hospital merger in Grand Rapids, Michigan. That testimony rested on empirical research purporting to show that in concentrated markets nonprofit hospitals generally had lower prices than corresponding for-profits.[12] Although that research had been effectively discredited in later economic studies,[13] the facts found in *Evanston*

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[12] FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1297 (W.D. Mich. 1996) (citing expert's findings suggesting "that a substantial increase in market concentration among nonprofit hospitals is not likely to result in price increases"). The expert cited by the court, William J. Lynk, reached the same conclusion in scholarly articles. William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437 (1995); William J. Lynk, *Property Rights and the Presumptions of Merger Analysis,* 39 ANTITRUST BULL. 363, 377 (1994).

[13] See DOSE OF COMPETITION, *supra* note 7, ch.4, at 33 (concluding "the best available evidence indicates that nonprofits exploit market power when given the opportunity to do so"); David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87 (1999); Emmett B. Keeler, Glenn Melnick, & Jack Zwanziger, *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69 (1999).

Northwestern should put finally to rest the notion that nonprofit hospitals are immune from the temptation to raise prices when they are in a position to do so.

Evanston Northwestern's findings also undercut the common belief that community leaders on a nonprofit hospital's governing board are vigilant about health care costs. The judge in the Grand Rapids case permitted the merger in part because the chairmen of the two hospitals' boards each represented a large local employer and "testified convincingly that the proposed merger [was] motivated by a common desire to lower health care costs . . . ."[14] In this same vein, a proponent of another hospital merger not long ago gave assurance that allowing it would not cause health insurance premiums to increase because several hospital "board members . . . are employers who worry about the cost of health-care."[15] Economists generally agree, however, that employees themselves, not employers, ultimately bear the cost of their own health coverage in reduced wages or other fringe benefits.[16] To be sure, employers are never happy to pay higher insurance premiums and would prefer to increase their employees' compensation in more visible ways. But they are ultimately committing their workers' money, not their own (or their shareholders'), in hospital boardrooms. Moreover, nonprofit hospitals

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[14] 946 F. Supp. at 1297.

[15] Felice J. Freyer, *Hospital Merger Reaction Cautious*, PROVIDENCE JOURNAL-BULLETIN, July 29, 2007, at B1 (describing proposed merger of Rhode Island's two largest hospital systems). See also FTC v. Freeman Hospital, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995) ("if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level, even if it has the power to do so")

[16] *See generally* Jonathan Gruber, *Health Insurance and the Labor Market* (Nat'l Bureau of Econ. Research, Working Paper No. 6762, 1998) (reviewing the empirical literature and finding "a fairly uniform result: the costs of health insurance are fully shifted to wages").

have few legal or institutional reasons to engage in only progressive redistribution.[17] In general, community leaders on nonprofit hospital boards have little incentive to resist any hospital project that seems good for the community if it can be financed from the hospital's reserves and future surpluses.

A recent report by the Massachusetts Attorney General documents how nonprofit hospitals in that state have aggressively exploited their market power, even when health care costs were strangling public and private budgets.[18] Following Massachusetts's passage of the nation's first legislative effort to achieve universal health coverage, the state legislature directed the Attorney General to analyze the causes of rising health care costs. The resulting report concluded that prices for health services are uncorrelated with either quality or costs of care but instead are positively correlated with provider market power.[19] The report further observed that prominent nonprofit academic medical centers—specifically, the Massachusetts General Hospital and Brigham and Women's Hospital, which had merged in 1993 to create Partners HealthCare—were most responsible for leveraging their market and reputational power to extract high prices from insurers.[20] Reporting by the *Boston Globe* had previously shown the surprising extent to which Partners was able to extract extraordinary prices in agreements

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[17] *See* Timothy Greaney & Kathleen Boozang, *Mission, Market and Trust in the Nonprofit Healthcare Enterprise*, 5 YALE J. HEALTH LAW & POL. 1 (2005); Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 22-24.
[18] Massachusetts Attorney General, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b)* (March 16, 2010), *available at: http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf* [hereinafter "Health Care Cost Trends"]
[19] *Id.* at 16-33.
[20] *Id.*; *see especially* 29-30.

with presumably cost-conscious insurers.[21] For example, when some insurers, such as the Tufts Health Plan, resisted Partners' demands for price increases and tried to assemble networks with Boston's other hospitals, Partners launched an aggressive marketing campaign that triggered threats by many of Tufts' corporate customers to switch insurers.[22]

The foregoing observations should finally dispel any impression that nonprofit hospitals, as community institutions, can safely be allowed to possess market power on the theory that, as nonprofits, they can be trusted not to exercise it.

B. Dispelling the Myth that Nonprofit Hospitals Use Profits for Charitable Purposes

Federal judges may have tolerated mergers conferring new market power on nonprofit hospitals less because they thought the hospitals would not exercise that power than because such hospitals seemed to differ from conventional monopolists in ways that should lessen social concern about their enrichment. Specifically, nonprofit, tax-exempt hospitals are required by their charters and the federal tax

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[21] Special Report: Unhealthy System, *available at*: http://www.boston.com/news/specials/healthcare_spotlight/ (detailing special reporting on Partners HealthCare, culminating in a three-part series); "A Healthcare System Badly Out of Balance," Boston Globe, Nov. 16, 2008; "Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs," Boston Globe, Dec. 21, 2008; "A Handshake That Made Healthcare History," Boston Globe, Dec.28, 2008.

[22] "A Handshake That Made Healthcare History," *id.*, (describing the "humiliation" experienced by the Tufts Health Plan's CEO as he caved to Partners' price demands and "became an object lesson for other insurers, a lesson they would not soon forget [as the] the balance of power had shifted" to Partners). In Orlando, insurer United Healthcare experienced similar threats as it resisted a request for a 63 percent price increase by the region's leading nonprofit hospital chain. Linda Shrieves, *400,000 Fear They'll Have to Switch Doctors*, ORLANDO SENTINEL, Aug.7, 2010.

code to retain their profits and use them only for "charitable" purposes. Thus, if one could assume that the redistributions of wealth resulting from the exercise of market power by nonprofit hospitals run generally from richer to poorer rather than in the opposite direction, there would be at least an argument for viewing nonprofit hospital monopolies as benign for antitrust purposes. Although such an argument would be based on a questionable reading of the antitrust statutes, one widely noted case allowed prestigious universities to act anti-competitively in order to direct their limited scholarship funds toward lower-income students.[23] One easily senses in hospital merger cases a similar judicial dispensation in favor of nonprofit enterprises that combine for seemingly progressive purposes.[24]

But however antitrust doctrine views (or should view) monopolies dedicated to progressive pursuits, it is far from clear that nonprofit hospitals reliably use their dominant market positions to redistribute wealth only in progressive directions. The Internal Revenue Code's charitable-purposes requirement has been interpreted very broadly, allowing such hospitals to spend their untaxed surpluses on anything that arguably "promotes health."[25] This includes much more than just caring for the indigent. Indeed, many exempt hospitals are located in areas that need relatively

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[23] United States v. Brown Univ., 5 F.3d 658 (3d Cir. 1993). Reading this ruling as an endorsement of the universities' redirection of scholarship funds to needier students would at least limit substantially (and prudently) the kind of worthy purpose a cartel of nonprofit entities may offer as an antitrust defense.
[24] *See, e.g., supra* note 9.
[25] Rev. Rul. 69-545, 1969-2 C.B. 117 (1969). Ironically, this controversial ruling, relaxing an earlier requirement that an exempt hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered," Rev. Rul. 56-185, 1956-1 C.B. 202, came at a time when the Medicare and Medicaid programs were relatively new and private health insurance was expanding, all seemingly reducing the need for nonprofit hospitals to be charitable in the original sense.

little in the way of truly charitable care, either because the community is relatively affluent and its population well-insured or because a public hospital assumes most of the charity burden. Moreover, although all hospitals inevitably subsidize the treatment of some uninsured patients, many of today's uninsured are members of the middle class and not obvious candidates for subsidies from the insured population.[26] Finally, federal, state, and local governments separately and substantially subsidize nonprofit hospitals' most clearly charitable activities, both through special tax exemptions and relief and by direct subventions; such activities therefore should not count significantly in estimating the net direction of redistributions effected by hospitals through the exercise of newly acquired market power.

Thus, true charity has in recent years accounted for only a relatively small fraction of what nonprofit hospitals do in return for their federal tax exemptions. Indeed, such hospitals can usually qualify for exemption merely by spending their surpluses on medical research, on training various types of health care personnel, and, most importantly, on acquiring state-of-the-art facilities and equipment, which (ironically) can also secure and enhance their market dominance.[27] Many of these

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[26] Supplemental census data from 2007 showed that nearly 38% of America's uninsured come from households with over $50,000 in annual income and nearly 20% from households with over $75,000. See U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES 21 table 6 (August 2007), http://www.census.gov/prod/2007pubs/p60-233.pdf . Implementation of the PPACA will greatly reduce hospitals' charity burdens, leaving illegal aliens as the principal category of the uninsured.

[27] On Partners HealthCare's use of its surpluses to build new and better facilities and expand into new markets, thereby securing additional market power, see "Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs," BOS. GLOBE, Dec. 21, 2008.

activities confer significant benefits on interests and individuals relatively high on the income scale.[28] To be sure, most of the activities and projects financed from hospital surpluses are hard to criticize in the abstract. But many of them are not so obviously progressive in their redistributive effects (or otherwise so obviously worthy of public support) that antitrust prohibitions should be relaxed so that hospitals can finance more of them.

In any case, financing hospital activities and projects of any kind from hospitals' monopoly profits causes their costs to fall ultimately and more or less equally on individuals bearing the cost of health insurance premiums. The incidence of this financial burden thus closely resembles that of a "head tax" – that is, one levied equally on individuals regardless of their income or ability to pay. Few methods of public finance are more unfair (regressive) than this. Those who take a

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Not only does tax exemption create opportunities for dominant firms to increase their dominance, but a nonprofit firm lacking such dominance may be ineligible for exemption – and thus at a severe competitive disadvantage – precisely because it faces competition and therefore lacks the discretionary funds necessary to demonstrate how it "benefits the community." Tax policy thus rewards, fosters, and protects provider monopoly, only ensuring that monopoly profits, however large, are not put to objectionable, non-health-related uses. *Cf.* Geisinger Health Plan v. Commissioner, 985 F.2d 1210, ___ (3d Cir. 1993) (denying tax exemption to nonprofit health plan in part because it was not a provider, but only arranged for the provision, of health services and also because, although it planned to subsidize premiums for some low-income subscribers, it had been "unable to support the program with operating funds because it operated at a loss from its inception").

[28] Many physicians, for example, benefit handsomely first from the valuable training hospitals provide and later from using expensive hospital facilities and equipment at no direct cost to themselves. The tax authorities regard such "private benefits" as merely "incidental" to the hospitals' larger purpose of promoting the health of the community. See I.R.S. Gen. Couns. Mem. 39,862 (Dec. 2, 1991): "In our view, some private benefit is present in all typical hospital-physician relationships. . . . Though the private benefit is compounded in the case of certain specialists, such as heart transplant surgeons, who depend heavily on highly specialized hospital facilities, that fact alone will not make the private benefit more than incidental."

benign view of the seemingly good works of health care providers should focus more attention on who (ultimately) pays for and who benefits from those nominally charitable activities.[29]

The regressive redistributive effects of nonprofit hospitals' monopolies appear never to have been given due weight in antitrust appraisals of hospital mergers.[30] To be sure, pure economic theory withholds judgment on the rightness or wrongness of redistributing income because economists have no objective basis for preferring one distribution of wealth over another. But the antitrust laws enjoy general political support principally because the consuming public resents the idea of illegitimate monopolists enriching themselves at their expense.[31] This is why mergers of all kinds are suspect in the eyes of antitrust enforcers: they may be an easy and unjustified shortcut to gaining market power. Although proponents of consolidations increasing concentration in provider markets usually tout efficiencies they expect to achieve by combining and rationalizing operations, the

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[29] *See generally* Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, LAW & CONTEMP. PROBS., Autumn 2006.

[30] Under reasonable assumptions, a hospital merger creating new market power would raise insurance premiums by roughly 3 percent, increasing the "head tax" on the median insured family by roughly $400 per year, hardly a trivial amount. In addition, according to one estimate, hospital mergers in the 1990s caused nearly 700,000 Americans to lose their private health insurance. Robert Town et al., *The Welfare Consequences of Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 12244, 2006).

[31] HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE 50 (3d ed. 2005) ("[T]he primary intent of the Sherman Act framers [was] the distributive goal of preventing monopolists from transferring wealth away from consumers.")

opportunity to increase their bargaining power vis-à-vis private payers is the likelier explanation for all such mergers in concentrated markets.[32]

In sum, a tragic failure of antitrust enforcement—fueled in no small part by certain sanguine attitudes toward nonprofit monopolies—contributed to what is now a crisis in provider markets. As a result, there are few markets in which price competition keeps prices for specific hospital and other health care services and goods near their marginal cost. The ubiquity of nonprofit hospitals with market power now constitutes a significant source of the provider-monopoly problem in health care.

III. The Particular Costliness of Healthcare Provider Monopolies: Market Power + Insurance

In economic theory, monopoly is objectionable because it enables a seller to charge higher prices that then cause some consumers, who would happily pay the competitive price, to forgo enjoyment of the monopolized good or service. Monopolists thus divert scarce resources to less-valued uses and reduce aggregate welfare. Fortunately, such output- and welfare-reducing (misallocative) effects are greatly lessened in health care markets because the large number of patients with

[32] *See* DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 122 (2000): "I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power." *See also* Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 699 (2010)., at 6 (quoting a local physician as saying, "Why are those hospitals and physicians [integrating]? It wasn't for increased coordination of care, disease management, blah, blah, blah – that was not the primary reason. The wanted more money and market share.")

health insurance can easily pay provider monopolists' asking prices for desirable goods or services rather than being induced to forgo their consumption. Unfortunately, however, health insurance has other, possibly more severe consequences because it both amplifies the redistributive effects of provider and supplier monopolies and contributes to allocative inefficiency of a different and arguably more serious kind.

A. Supra-Monopoly Pricing

In the textbook model, monopoly redistributes wealth from consumers to powerful firms. The monopolist's higher price enables it to capture for itself much of the welfare gain, or "surplus," that consumers would have enjoyed if they had been able to purchase the valued good or service at a low, competitive price. In health care, insurance puts the monopolist in an even stronger position by greatly weakening the constraint on its pricing freedom ordinarily imposed by the limits of consumers' willingness or ability to pay. This effect appears in theory as a steepening of the demand curve for the monopolized good or service. Whereas most monopolists encounter a reduction in demand with each price increase, health insurance mutes the marginal consequences of rising prices.

If health insurers were dutiful agents of their subscribers and perfectly reflected subscribers' preferences, they would reflect consumers' demand curve and pay only for services that were valued by individual insureds at levels higher than the monopoly price. Deficiencies in the design and administration of real-world health insurance, however, prevent insurers from reproducing their insureds' preferences and heavily magnify monopoly power. For legal, regulatory, and other

reasons, health insurers in the United States are in no position (as consumers themselves would be) to refuse to pay a provider's high price whenever it appears to exceed the service's likely value to the patient. Instead, insurers are bound by both deep-rooted convention and their contracts with subscribers to pay for any service that is deemed advantageous (and termed "medically necessary" under rather generous legal standards) for the patient's health, whatever that service may cost.[33]

Consequently, close substitutes for a provider's services do not check its market power as they ordinarily would for other goods and services. Indeed, putting aside the modest effects of cost sharing on patients' choices, the only substitute treatments or services that insured patients are likely to accept are those they regard as the best ones available. Unlike the situation when an ordinary monopolist sells directly to cost-conscious consumers, the rewards to a monopolist selling goods or services purchased through health insurance may easily and substantially exceed the aggregate consumer surplus that patients would derive at competitive prices.

Thus, health insurance enables a monopolist of a covered service to charge substantially more than the textbook "monopoly price," thereby earning even more than the usual "monopoly profit." The magnitude of the monopoly-plus-insurance

[33] See generally Timothy P. Blanchard, "Medical Necessity" Determinations—A Continuing Healthcare Policy Problem," Journal of Health Law 37, no. 4 (2003): 599–627; William Sage, "Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance," Duke Law Journal 53 (2003): 597; Einer Elhauge, "The Limited Regulatory Potential of Medical Technology Assessment," Virginia Law Review 82 (1996):1525–1617.

distortion has sometimes even surprised its beneficiaries.[34] Of course, since third-party payors (and not patients) are covering the interim bill, these extraordinary profits made possible by health insurance are earned at the expense of those bearing the cost of insurance. Insureds, even when their employers are the direct purchasers of health insurance, are ultimately the ones seeing their take-home shrink from hikes in insurance premiums caused by provider monopolies.

Discussions of antitrust issues in the health care sector rarely, if ever, explicitly observe how health insurance in general or U.S.-style insurance in particular enhances the ability of dominant sellers to exploit consumers. Although scholars have previously observed that prices for health services are much higher in the United States compared to other OECD nations (without observable differences in quality),[35] and although many have observed that provider market power has been a significant factor in inflating those prices,[36] few have observed the synergistic effects of monopoly and health insurance.

Perhaps more notably, despite the huge implications for consumers and the general welfare, the special redistributive effects of monopoly in health care markets are not mentioned in the antitrust agencies' definitive statements of

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[34] For truly stunning examples of the price-increasing and profit-generating effects of combining US-style health insurance and monopoly, see Geeta Anand, "The Most Expensive Drugs," Parts 1–4, Wall Street Journal, November 15–16, December 1, 28, 2005; in this series, see especially "How Drugs for Rare Diseases Became Lifeline for Companies," November 15, 2005, A1 (in which one drug company executive is quoted as saying, "I never dreamed we could charge that much.")
[35] See, e.g., Diana Farrell et al., Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More, (McKinsey Global Institute, 2008).
[36] *See supra*, notes 2-3.

enforcement policy in the health care sector.[37] Antitrust analysis of hospital mergers—as well as of other actions and practices that enhance provider or supplier market power—must therefore explicitly recognize the impact of insurance on health care markets. The nation will find it far harder, perhaps literally impossible, to afford PPACA's impending extension of generous health coverage to additional millions of consumers if monopolists of health care services and products can continue to charge not what "the market" but what insurers will bear.

B. Misallocative Consequences

Allowing providers to gain market power by merger not only causes extraordinary redistributions of wealth but also contributes to inefficiency in the allocation of resources. In ironic contrast to the output restrictions associated with monopoly in economic theory, the misallocative effects cited here mostly involve the production and consumption of too much—rather than too little—of a generally good thing. These misallocations are both theoretically and practically important. They provide still another new reason for special antitrust and other vigilance against providers' monopolistic practices, particularly scrutinizing anticompetitive mergers and powerful joint ventures.

Even in the absence of monopoly, conventional health insurance enables consumers and providers to overspend on overly costly health care. This is, of course, the familiar effect of moral hazard—economists' term for the tendency of patients and providers to spend insurers' money more freely than they would spend the patient's own. To be sure, some moral-hazard costs are justified as an

[37] *See supra*, note 7.

unavoidable price to protect individuals against unpredictable, high-cost events. But American health insurers are significantly constrained in introducing contractual, administrative, and other measures to contain such costs. U.S.-style health insurance is therefore more destructive of allocative efficiency than health insurance has to be. Although uncontrolled moral hazard is a problem throughout the health sector, combining inefficiently designed insurance with provider monopolies compounds the economic harm.

The extraordinary profitability of health-sector monopolies also introduces a dynamic source of resource misallocation by greatly strengthening the usual inducement for firms to seek market dominance. The introductions of new technologies have been a major source—perhaps primary, responsible for as much as 40-50 percent—of healthcare cost increases over the past several decades.[38] And even though many innovations offer only marginal value, their monopoly power under intellectual property laws secure lucrative payments from insurers whose hands are tied. Although many have recognized that new technologies are a principal source of unsustainable increases in health care costs, and several others have recognized how the moral hazard of insurance has both fueled technology-driven cost increases and distorted innovation incentives (toward cost-increasing

[38] Daniel Callahan, "Health Care Costs and Medical Technology," in From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns, ed. Mary Crowley (Garrison, NY: The Hastings Center, 2008), 79–82. See also Paul Ginsburg, "Controlling Health Care Costs," New England Journal of Medicine 351 (2004): 1591–93; Henry Aaron, Serious & Unstable Condition (Washington, DC: Brookings Institution Press, 1991).

innovations at the expense of cost-reducing innovations),[39] few have appreciated the contributing role of insurance in exacerbating the monopolies' effects.

Provider monopolies also inflict economic harm by spending heavily to sustain current monopoly barriers. Indeed, Richard Posner has theorized that monopoly's most serious misallocative effect is not the output reduction recognized in theoretical models but instead is the monopolist's strenuous efforts to obtain, defend, and extend market power.[40] A monopolist is willing to invest up to the private value of its monopoly in maintaining it (and keeping out competitors), and the more lucrative the monopoly, the more a firm will be induced to invest heavily in sustaining monopoly barriers. Since so many monopolies are maintained with legal and regulatory barriers—certificate-of-need laws, accreditation, and contracts restricting provider networks, for example—much of this effort is spent on legal and political resources that fritter away the private value of the monopoly, rather than reinvesting in activities that create additional social value. Even managers of nonprofit firms, though they have no interest in profits as such, have incentives to maintain monopolies to fund the construction and expansion of empires that

[39] See Alan M. Garber, Charles I. Jones, and Paul M. Romer, "Insurance and Incentives for Medical Innovation" (working paper 12080, National Bureau of Economic Research, 2006); Burton Weisbrod, "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," Journal of Economic Literature 29, no. 2 (June 1991): 523–52; Sheilah Smith, Joseph P. Newhouse, & Mark Freeland, "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" Health Affairs 28, no. 5 (2009): 1276–84. See also Dana Goldman and Darius Lakdawalla, "Understanding Health Disparities across Education Groups" (working paper 8328, National Bureau of Economic Research, 2001) (suggesting that population-wide increases in education have encouraged pursuit of patient-intensive innovations that increase costs, rather than simpler technologies that reduce them).

[40] Richard A. Posner, Antitrust Law: An Economic Perspective, 2nd ed. (University of Chicago Press, 2001), 13–18.

enhance their self-esteem and professional influence. Such empire building is most easily accomplished by obtaining market power and using it to generate surpluses with which to further entrench and extend the firm's dominance.

In light of the disproportionately large share of national resources already being spent on health care in the United States compared to every other nation in the world, and especially once one recognizes the extraordinary pricing freedom that U.S.-style health insurance confers on monopolist providers and suppliers, the enormous burden of distortive health-sector monopolies provide compelling, even alarming, reasons to apply the antitrust laws with particular force. Antitrust policymakers, I believe, are up to the task of restoring competition in healthcare markets where it is lacking, but it will require targeting providers and suppliers of health services seeking to achieve, entrench, and enhance market power.

IV. A New Antitrust Agenda

Can government, through antitrust enforcement or otherwise, do anything about the problem of provider and supplier market power in health care markets? Although the enforcement agencies and courts should certainly scrutinize new hospital mergers and similar consolidations with greater skepticism, preventing new mergers cannot correct past failures to maintain competition in hospital and other markets. Enforcers may challenge the legality of previously consummated mergers, as the FTC did in the Evanston Northwestern case, but there are practical and judicial difficulties in fashioning a remedy that might restore the competition that the original merger destroyed. The FTC was unwilling, for example, to demand

the dissolution of Evanston Northwestern Healthcare Corp. and instead merely ordered its jointly operated hospitals to negotiate separate contracts with health plans—a remedy, incidentally, that gave the negotiating team of neither hospital any reason to attract business from the other.[41] Although the FTC might seek more substantial relief in other such cases, the general rule seems to be that old, unlawful mergers are amenable to later breakup only in the unusual case where the component parts have not been significantly integrated.[42] In any case, given their past skepticism about antitrust enforcement in health care markets, and especially their hand in blessing many mergers that ought now be unwound, courts would be hard to enlist in an antitrust campaign to roll back earlier consolidations.[43]

Thus, a policy agenda capable of redressing the provider monopoly problem in health care will need to employ other legal and regulatory instruments. A first order of business would be to fastidiously prevent the formation of new provider monopolies. Because healthcare providers continue to seek opportunities to consolidate—either through the recent wave of forming Accountable Care Organizations ("ACOs") or though alternative means—there remain several fronts available for policymakers to wage antitrust battle. In addition, an array of other

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[41] Despite losing thoroughly on the merits, the respondent declared itself "thrilled" with the FTC's remedy. See North Shore University Health Systems "FTC Ruling Keeps Evanston Northwestern Healthcare Intact," press release, August 6, 2007, www.northshore.org/about-us/press/pressreleases/ftc-ruling-keeps-evanston-northwestern-healthcareintact/ (accessed May 3, 2012).
[42] See, for example, United States v. E.I. du Pont de Nemours & Co., 353 U.S. 586 (1957); see also Phillip Areeda and Herbert Hovenkamp, Antitrust Law 2nd ed. (New York: Aspen Publishers, 2003): 1205b.
[43] For a chronicling of government challenges to mergers that lost in federal court, see Dose of Competition, *supra* note 7. For an exploration of judicial resistance to enforcing the antitrust laws against hospitals, see Richman, *supra* note 8.

enforcement policies can target monopolists behaving badly—those trying either to expand their monopoly power into currently competitive markets or to foreclose their market to possible entrants. Thus, several fronts remain available for policymakers seeking to restore competition to healthcare markets. A new antitrust agenda begins with recognizing the extraordinary costs to healthcare provider monopolies and continues with aggressive and creative antimonopoly interventions.

A. The Special Problem of Accountable Care Organizations

A primary target for a revived antitrust agenda is the emerging Accountable Care Organizations, whose development the Affordable Care Act is designed to stimulate. The ACA encourages providers to integrate themselves in ACOs for the purpose of implementing "best practices" and thereby providing coordinated care of good quality at low cost. As an inducement for providers to form and practice within these presumptively more efficient entities, the ACA instructs the Medicare program to share with an ACO any cost savings it can demonstrate, permitting proposed ACOs either to keep any savings beyond a minimum savings rate ("MSR") of up to 3.9% while being insured against losses if savings are not obtained or to keep savings beyond an MSR of 2% while being exposed to the risk of losses.[44] ACOs are being hailed as a meaningful opportunity to reform our deeply inefficient delivery system, but the unintended consequences of promising health policy initiatives often invest prematurely in projects that ultimately disappoint. The

[44] See Department of Health and Human Services, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 CFR Part 425, Federal Register 76, no. 212 (November 2, 2011): 67802, 67985–88.

formation of ACOs run the specific risk of creating even more aggregation of pricing power in the hands of providers.

ACOs, in theory, could offer an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery system.[45] Together with good information systems and compensation arrangements, vertical integration of complementary health care entities can achieve important efficiencies by reducing medical errors, obviating duplicative services and facilities, and coordinating elements needed to deliver high quality, patient-centered care.[46]

Skeptics, who include former FTC Commissioner Thomas Rosch, note that "available evidence suggests that the cost savings [from ACOs] will be very small to nonexistent" and warn that any purported reductions in expenditures "will simply be shifted to payors in the commercial sector."[47] Others have warned that efforts to replicate early successes in integrated delivery systems—which serve as models for reformers' aspirations—have often failed, in part because many physicians are reluctant to forgo the lucrative possibilities of unconstrained fee-for-service practice and in part because physicians who do integrate with hospital systems predictably resist adhering to efficiency-enhancing management. Moreover, many ACOs are reportedly being sponsored by hospitals, which any efficient delivery system would use sparingly. Hospital investments might be designed to preempt control of ACOs,

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[45] Einer Elhauge, ed., The Fragmentation of US Health Care (Oxford, UK: Oxford University Press, 2010).
[46] Alain C. Enthoven and Laura A. Tollen, "Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency," Health Affairs (September 7, 2005), doi:10.1377/hlthaff.w5.420.
[47] Remarks of J. Thomas Rosch before the ABA Section of Antitrust Law, November 17, 2011.

rather than harness their potential efficiencies, so any cost savings will come at the expense of others and not themselves.

In contrast to the varying views on the potential benefits of ACOs, there is widespread agreement that they could engineer and leverage greater monopoly power in an already-concentrated healthcare market.[48] Organizers of ACOs are forging collaborations among entire markets of physicians and hospitals, entities that would otherwise compete with each other. The New York Times has reported "a growing frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings, and cash in on the [ACO program's] incentives."[49] In fact, providers' main purpose in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen their market power over purchasers in the private sector. ACOs "may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to

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[48] See America's Health Insurance Plans, Accountable Care Organizations and Market Power Issues (October 2010), www.ahip.org/Workarea/linkit.aspx?ItemID=9222 (accessed May 25, 2012); Berenson, Ginsburg, and Kemper, "Unchecked Provider Clout" (which notes ACOs' "potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power"); and Jeff Goldsmith, "Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms," Health Affairs 29, no. 7 (2010): 1299, 1304. ("Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen.").

[49] Robert Pear, "Consumer Risks Feared as Health Law Spurs Mergers," New York Times, November 20, 2010.

the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations."[50]

Antitrust policymakers therefore should carefully scrutinize the formation of ACOs. Conventional antitrust reasoning appropriately permits purported efficiency claims to trump concerns about concentration on the seller side of the market, and any review of a proposed ACO would certainly consider the potential benefits of vertical integration. But any antitrust analysis should also recognize that health insurance greatly exacerbates the price and misallocative effects of monopoly. Notwithstanding the special efficiency claims that can be made on behalf of ACOs, the potency of healthcare monopolies provides a strong warrant for an especially stringent anti-concentration, antimerger policy in the health care sector. These heightened dangers should be weighed heavily in appraising an ACO's likely market impact.

Antitrust policymakers therefore should carefully scrutinize the formation of ACOs. Conventional antitrust reasoning appropriately permits efficiency claims to overcome concerns about concentration on the seller side of the market, and any review of a proposed ACO would certainly consider the potential benefits of vertical integration. But any antitrust analysis should also recognize that health insurance greatly exacerbates the price and misallocative effects of monopoly. Notwithstanding the special efficiency claims that can be made on behalf of ACOs, the potency of health care monopolies strongly warrants especially stringent anti-

[50] Barak Richman and Kevin Schulman, "A Cautious Path Forward on Accountable Care Organizations," Journal of the American Medical Association 305, no. 6 (February 9, 2011): 602–03.

concentration, anti-merger policy in the health care sector. These heightened dangers should be weighed heavily in appraising an ACO's likely market impact.

It remains unclear what role the FTC and DOJ have in applying this necessary level of scrutiny to new ACO proposals. But the antitrust agencies surely enjoy a good deal of discretion in ensuring that ACO complies with the principles of competition. The agencies could demand a heightened showing that a proposed consolidation will generate identifiable efficiencies, and they similarly might demand that an ACO's proponents assume the burden of showing an absence of significant horizontal effects in local submarket. The agencies similarly could impose demanding cures to illegal concentrations, perhaps encouraging the vertical integration envisioned by PPACA's proponents while reducing the horizontal collaboration that providers so routinely pursue. Finally, the agencies could also impose conduct (i.e. non-structural) remedies to potentially harmful ACOs, such as requiring nonexclusive contractual arrangements with payors and with regional hospitals, or pledging to undo certain integrations if prices proceed to rise above a certain threshold. How the FTC and DOJ monitor the formation of ACOs could determine whether the ACA meaningfully advances a (desperately needed) reorganization of healthcare delivery or merely offers a loophole to permit greater consolidation.

The CMS might also serve a meaningful role in preventing ACOs from furthering anticompetitive harm in healthcare marketplaces. The final rules permit CMS to share savings with ACOs only after a showing of quality benchmarks, which CMS administrators ought to take seriously. The rules also require cost and quality

reporting, and CMS might require a demonstration of meaningful quality improvements and cost savings in order to receive a continued share of Medicare savings. CMS might even condition an ACO's permission to market to private payers on a demonstration that its prices to private payers did not increase significantly following its formation.

One might wonder, of course, whether a governmental single payer like Medicare has the mission, the impulse, or the requisite creativity to be helpful in making private markets for health services effectively competitive. Perhaps CMS's new Center for Medicare and Medicaid Innovation could shape the institution's capacity to affect reform. It might be equally likely, unfortunately, that Medicare will aim to preserve its own solvency by encouraging the shifting of costs to the private sector—and may even reward ACOs' cost shifting as cost savings. This is the danger with using a large and unavoidably inflexible bureaucracy to engineer an effort to induce innovation. Nonetheless, you go to war with the bureaucracy you have, and CMS ought to concentrate on developing competition-oriented regulations and cautiously monitor the market impact of emerging ACOs.

B. Requiring Unbundling of Monopolized Services

Any effort to restore price competition in healthcare markets must include a strategy that targets already-concentrated markets. Antitrust enforcers therefore need to develop policy instruments that target current monopolists, both to limit the economic harm they inflict and to thwart their efforts to expand their monopoly power.

One promising initiative could be to require hospitals and other provider entities to unbundle, at a purchaser's request, certain services for the purposes of negotiating prices. Providers routinely bundle services for unified payments, and many such bundles serve efficiency purposes. Some services are so intertwined that separating them proves costly, and similarly, many clinically related services offer efficiencies when sold together. However, when providers bundle services in markets they have monopolized with services in which there is competition, a menu of anticompetitive consequences can result: the monopolist can squeeze out rivals in the competitive market, creating for itself another monopoly; and by squelching rivals in the competitive market, the monopolist limits the ability of entrants to challenge its hold on the monopolized market. The magnified consequences of healthcare monopolies should heighten concern over practices that can expand or enshrine provider monopolists.

The general antitrust rule on tying is that a firm with market power may not use it to force customers to purchase unwanted goods or services.[51] If this principle is invoked to frustrate hospitals' practice of negotiating comprehensive prices for large bundles of services, purchasers could then bargain down the prices of services with good substitutes.[52] If a hospital still wished to fully exploit its various monopolies, it would have to do so in discrete negotiations, making its highest prices visible. Health plans could then hope to realize significant savings by

[51] See Jefferson Parish Hosp. Dist. No. 2. v. Hyde, 466 U.S. 2 (1984).
[52] The ability to leverage market power in one sub-market into price increases in a competitive market helps explain wide price variation for like services in common geographic markets. See Paul B. Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," HSC Research Brief no. 16 (November 2010), www.hschange.com/CONTENT/1162/ (accessed May 25, 2012).

challenging such monopolies, either by inducing enrollees to seek care in alternative venues (effectively expanding the geographic market) or by encouraging new entry. Often the mere threat of new entry is sufficient to modify a monopolist's demands, but entry is more credible if the monopolized service is discrete and associated with a distinct price that entrants can target.

To date, there have been only limited enforcement efforts to prevent hospitals from tying their services together in bargaining with private payers.[53] Although hospitals would predictably argue that bundling generally makes for efficient negotiating and streamlined delivery of care, the added costs of bargaining service by service could be easily offset by the lower prices resulting from greater competition. Recent scholarship on tying and bundling confirms that permitting a hospital monopolist to tie unrelated services expands the monopoly's reach, profitability, and longevity and harms consumer welfare.[54] The extreme harm from healthcare monopolies makes hospitals' tying practices particularly vulnerable to antitrust attack.

A workable rule would permit antitrust law to empower a purchaser to demand separate prices for divisible services that are normally bundled.[55]

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[53] In a private suit, a dominant hospital chain was sued by its lone rival for, among other things, bundling primary and secondary services with tertiary care in selling to the area's insurers. See Cascade Health Solutions v. PeaceHealth, 515 F.3d 883, 890–91 (9th Cir. 2008). The district court permitted certain claims to proceed to trial, including a claim of illegal bundled discounts, but dismissed the tying claim.
[54] See Einer Elhauge, "Tying, Bundled Discounts, and the Death of the Single Monopoly Profit Theory," Harvard Law Review 123, no. 2 (2009): 397–481.
[55] This proposal is in line with recommendations from the Antitrust Modernization Commission, Report and Recommendations (April 2007): 96, http://permanent.access.gpo.gov/lps81352/amc final report.pdf (accessed May 9, 2012). What is "divisible" in health care is of course subject to debate, just as most

Although one hopes that antitrust courts and a credible threat of treble damages would discourage a provider monopolist from retaliating against any purchaser that aggressively challenges its anticompetitive practices, the costs and delay from such complex antitrust actions suggest that public enforcement should supplement private suits. Properly authorized regulators could either enable individual payers to demand unbundling to facilitate their efforts to get better prices, or regulators could demand it themselves. Effective unbundling requests could trigger more competition and greater efficiency both in the tied submarkets where monopoly is not a problem and also in the tying markets where it is.

C. Challenging Anticompetitive Terms in Insurer-Provider Contracts

Restrictive terms in contracts between providers and insurers are another potentially fruitful area for antitrust and regulatory attention in dealing with the provider monopoly problem. A common practice, for example, is for a provider-seller to promise to give an insurer-buyer the same discount from its high prices as any it might give to a competing health plan. Such price-protection, payment-parity, or "most-favored-nation" (MFN) clauses are common in commercial contracts and serve to obviate frequent and costly renegotiation of prices. Their efficiency benefits may sometimes be outweighed by anticompetitive effects, however. Thus, a provider monopolist may find that a large and important payer is willing to pay its very high prices only if the provider promises to charge no lower prices to its competitors. Such a situation apparently arose in Massachusetts, where the

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services accused of being bundled are often defended as a single product. See, for example, Jefferson Parish Hosp., 466 U.S., 19–22.

Commonwealth's largest insurer, a Blue Cross plan, reportedly acceded to Partners HealthCare's demand for a very substantial price increase only after Partners agreed to "protect Blue Cross from [its] biggest fear: that Partners would allow other insurers to pay less."[56]

Antitrust law can offer relief against a provider monopolist agreeing to an MFN clause to induce a powerful insurer to pay its high prices. Because such clauses protect insurers against their competitors' getting better deals, many are likely to give in too quickly to even extortionate monopolist price demands. But the availability of an antitrust remedy (which would probably be only a prospective cease-and-desist order rather than an award of treble damages for identifiable harms) might not be sufficient to deter a powerful provider from granting MFN status to a dominant insurer. Alternatively, regulatory authorities could presumably prohibit dominant providers from conferring such status. Regulators presumably would be in as good a position as any party to distinguish between restrictive agreements that achieve transactional efficiencies from agreements that restrict insurers' freedom to cut price deals with competitors and reduce pressure on, and opportunities for, all insurers to seek new and innovative service arrangements.

A more potent antitrust attack on anticompetitive MFN clauses would aim at the dominant insurer demanding them, rather than at the cooperating provider.

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[56] "A Handshake That Made Healthcare History," Boston Globe, Dec. 28, 2008. The Massachusetts attorney general has noted that such payment-parity agreements have become "pervasive" in provider-insurer contracts in the commonwealth and has expressed concern that "such agreements may lock in payment levels and prevent innovation and competition based on pricing." Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers (March 16, 2010), 40–41.

The Department of Justice (DOJ) sued Blue Cross Blue Shield of Michigan, a dominant insurer, to enjoin it from using MFN clauses in its contracts with Michigan hospitals. The DOJ alleged that such restrictions on provider price competition reduced competition in the insurance market by preventing other insurers from negotiating favorable hospital contracts.[57] In the wake of the government's initiative in Michigan, which resulted in a settlement, Michigan (and subsequently several other states) have prohibited the use of MFN agreements between health insurers and providers. Even without state regulations prohibiting MFN clauses, the DOJ theory met sufficient support that in Massachusetts, for example, the Blue Cross plan should now think long and hard before renewing (or enforcing) the MFN clause in its contract with Partners HealthCare.

Other contract provisions that threaten price competition are also in use in provider-insurer contracts in Massachusetts, according to the Commonwealth's Attorney General. In particular, so-called "anti-steering" provisions prohibit an insurer from creating insurance products in which patients are induced to patronize lower-priced providers. Under such a contractual constraint, a health plan could not offer more generous coverage—such as reduced cost-sharing—for care obtained from a new market entrant or from a more distant, perhaps even an out-of-state or out-of-country, provider. Other contractual terms in use in Massachusetts (and presumably in other jurisdictions as well) guarantee a dominant provider that it will

[57] See Complaint at 1-2, United States v. Blue Cross Blue Shield of Mich. (E.D. Mich. 2010) (No. 2:10-CV-14155); see also David S. Hilzenrath, "U.S. Files Antitrust Suit Against Michigan Blue Cross Blue Shield," Washington Post, October 18, 2010.

not be excluded from any provider network that the health plan might offer its subscribers.

The contractual terms noted here all have the potential to enshrine the cooperative supremacy of dominant providers and dominant insurers. The resulting competitive hard extends beyond the sustenance of high prices. These partnerships also foreclose opportunities for consumers to benefit, both directly as patients and indirectly as premium payers, from innovative insurance products that competing health plans might otherwise introduce. Antitrust law can prohibit the use of such anticompetitive contract terms that protect provider monopolies and curb insurer innovation, and insurance regulators might bar such provisions wherever they threaten to preclude effective price competition. These actions remain available even in the continued presence of a provider monopoly.

V. Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving insured healthcare consumers exposed to monopolized healthcare markets. Because health insurance, especially as it is designed and administered in the United States, hugely expands a monopolist's pricing freedom, providers with market power inflict wealth-redistributing and misallocative effects substantially more serious than conventional monopoly power.

Vigorous—not tentative or circumspect—enforcement of the antitrust laws can mitigate the harms from provider market power. Retrospective scrutiny on earlier

horizontal mergers of hospitals or other providers could help correct decades of ineffectual enforcement, but if looking backwards remains unlikely, renewed rigor moving forward is all-the-more essential. Parties proposing new mergers and alliances, whether traditional associations or new ACOs, must convincingly show that their reorganization either leads to only a minimal increase in market power or creates specific efficiencies. Other measures should target current monopolists, so as to prevent the enshrinement or expansion of their market dominance. An antitrust or regulatory initiative to curb hospitals' tying practices and to prohibit anticompetitive contracts between payers and providers—perhaps as remedies for earlier mergers found unlawful after the fact—might also significantly reduce the extraordinary pricing freedom that hospital and other monopolists enjoy by virtue of U.S.-style health insurance.

Enthusiasts for market-oriented solutions would also seek reductions to provider market power by encouraging creativity among third-party purchasers. Health plans that bypass, or foster new competitors for, local monopolists promote price and quality competition where it is currently lacking, could undermine the potency of insurance-plus-monopolies. A pro-competition regulatory agenda might seek ways to facilitate inter-regional competition and empower third-party payors to seek flexible and creative strategies to stimulate provider competition. Additional hope lies in the possibility that health insurers and third-party purchasers will purchase (and that ACA regulations will let them purchase) proven non-medical interventions that improve health and reduce healthcare costs. The exorbitant prices for monopolized medical services should encourage health

insurers to develop creative alternatives, both seeking effective (and less-costly) substitutes and reorganizing what has become a fragmented, error-prone, and inefficient delivery of care.

Unfortunately, health insurers have not shown much eagerness either to contest provider market power or to pursue meaningful innovations to providing care for their subscribers. As investigations in Michigan and Massachusetts reveal, insurers all-too-often become co-conspirators with provider monopolists, agreeing to exclusive agreements that protect both themselves and monopolists but unforgivingly gouge consumers. Insurers' failure to act as aggressive purchasing agents of consumers is partly due to the hiding of the true cost of insurance and partly due to consumers' undue reluctance to accept anything less than the very best—even close substitutes. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their insurers. Dominant U.S. health plans appear inadequately incentivized to reduce costs and overly hesitant to adopt innovative strategies with associated legal or political risks. Any hopefulness for the future of U.S. health care is tempered by doubts about the ability and willingness of U.S. health insurers—as well as insurance regulators and elected officials that purchase insurance for public employees—to take the aggressive actions needed to procure appropriate, affordable care.

The ACA, by providing conventionally generous health insurance to many million more Americans, has the potential to aggravate and extend the significant shortcomings of such insurance. Not only does the new law seem to have no

effective answer to the problem of provider and supplier monopolies, but its broad extension of coverage is likely to further amplify the uniquely harmful effects of their market power. Moreover, its new regulatory requirements—the impositions of medical loss ratios and essential health benefits, for example—might constrain innovations among payors to create inter-regional provider competition and reconfigure a deeply inefficient healthcare delivery system.

However, the ACA also has the capacity to open up the insurance market. Many consumers will, for the first time, realize the full cost of health insurance, which perhaps—via sticker shock—induce them to demand lower-cost alternatives. Moreover, the insurance exchanges might offer a platform for new entry in the insurance market, thus injecting some dynamism to an industry desperately in need of creative ideas. And regardless of how the new insurance markets take shape, antitrust policymakers and other regulators still have the capacity to foster value-enhancing innovation—both by preventing tactics that might enshrine the current monopolist regime and also by promoting the development of new insurance products. Although current tax policies and regulations have dulled many insurers into being agents for providers rather than for their subscribers, there remains a potent opportunity for third-party payors to inject the healthcare sector with value-creating innovations that redesign both the offerings and the delivery of care.

Whatever the PPACA may achieve, its legacy and cost to the nation will depend largely on whether market actors, regulators, and antitrust enforcers can effectively address the provider monopoly problem and to instill desperately needed competition among providers. Aggressive antitrust enforcement can prevent

further economic harm and perhaps can undo costly damage from providers that in error were permitted to become monopolists. But ultimately, creative market and regulatory initiatives will be needed to unleash the competitive forces that consumers need. Where there is danger, there is opportunity, and competition-oriented policies can and should yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources that appear to become increasingly limited.

Mr. BACHUS. Thank you. We appreciate that testimony, Professor.

Mr. Miller, number two, Mr. Thomas Miller instead of Mr. Joe Miller.

TESTIMONY OF THOMAS P. MILLER, J.D., RESIDENT FELLOW IN HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE

Mr. THOMAS MILLER. Thank you, Mr. Chairman and Members of the Subcommittee, for the opportunity to testify today on health care consolidation and competition under the Affordable Care Act.

Health care providers with market power enjoy substantially pricing freedom than monopolists in other markets, as Professor Richman further explains in his testimony. Traditional antitrust enforcement tools did little to halt extraordinary consolidation in local hospital markets over the last 2 decades, which drove higher price increases for in-patient services. Comprehensive U.S.-style health insurance further enhances the pricing freedom of health care firms with market power. The ACA also does little to address the monopoly problem and may even worsen it.

Problems of excessive concentration and insufficient competition in health care markets are not new, although their industry sector source has varied over time. Most recently, markets for our hospital services have presented the more serious competition policy issues.

A less-noted future problem involves the increased political competition under the ACA among dominant health sector players to obtain, maintain, or extend their market power advantages. The highly regulated and heavily subsidized regime ahead already has triggered a feverish scramble among health businesses to get bigger and also become better connected politically to ensure that they will be among the politically dependent survivor incumbents in the years ahead. With most of the key decisions in health care financing, coverage, and even treatment likely to be made in Washington, investments in winning future rounds of political competition is likely to trump responsiveness to market competition.

Hence, we have seen even more health care market consolidation since passage of the ACA. The primary effect of the law and its increasingly dense web of regulation has been to encourage a substantial increase in vertical integration and consolidation of health care services, mostly in the form of acquisitions of physician practices by hospitals. Increased vertical and even horizontal consolidation potentially could improve the allocation of health care resources but it also risks coming into conflict with pro-competition policies favoring greater price transparency, improved quality reporting, and lower prices. Well-integrated health provider networks or health systems may face less competition, lock in patients to non-interoperable health IT systems, and leverage market power across health services domains.

One strong factor in the move toward greater consolidation of health care services is the continued likelihood of tighter reimbursement limits combined with cost increasing mandates that would shift more financial risk to providers.

On the health insurance side, post-ACA-enactment consolidation has not been as rapid thus far. However, longer-term factors suggest that this is likely to change. The new health exchanges or, as I like to call them, marketplaces without market prices are structured to gravitate toward more standardized corridors of coverage. It is important to distinguish between short-term effects as the ACA exchanges begin their first shakedown year of implementation and the more likely longer-term dynamics of this more heavily regulated and tax-subsidized market for individual and small group insurance.

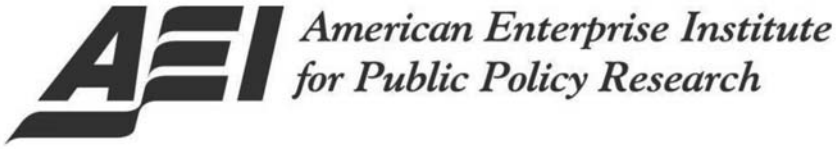
Passage of the ACA triggered a new wave of defensive consolidation in the health care sector instead of just presenting better opportunities to reconfigure operations and business relationships to become more efficient. Anti-competitive strategies were predictable responses to the new law's incentives and penalties. Under the ACA's regime of complex, confusing, and costly regulation, it will take a larger village of lawyers, lobbyists, and lines of credit to comprehend, cope and comply or maneuver around this. Growing bigger or staying large becomes the best hedge against political and regulatory risks.

The evolving regulatory balance, of course, does remain unsteady and is not fully charted at this time. Well, is this time different? Antitrust enforcers should be congratulated for recently ending their long losing streak in the courts in challenging hospital mergers seemingly likely to reduce competition and raise prices. But prospects for addressing competition problems in the ACA era of health care markets through conventional antitrust enforcement remain limited. Better antitrust policy still has an important role to play in ensuring more competitive health care practices. We need expanded solutions to the chronic problems of too much concentration and too little competition.

Beyond tighter review of new hospital mergers and consolidations, they should include curbing new abuses of State action immunity, challenging anticompetitive terms in insurance provider contracts, requiring unbundling of monopolized health care services, promoting inter-regional competition in health care services, removing or limiting regulatory barriers to entry by new health sector competitors, ensuring that new accountable care organizations deliver on their promises rather than facilitate aggregation and abuse of market power, and finally, empowering consumers and private purchasers with better information tools.

Thank you very much.

[The prepared statement of Mr. Thomas Miller follows:]



Statement before the House Committee on the Judiciary

Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Hearing

The Patient Protection and Affordable Care Act,
Consolidation, and the Consequent Impact on Competition in Healthcare

More Consolidation & More "Political" Competition, Less Patient-Centered Market Competition

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September 19, 2013

Summary Points

- Health care providers with market power enjoy more pricing freedom than monopolists in other markets
- Traditional antitrust enforcement did little to halt extraordinary consolidation in local hospital markets over the last two decades
- The Affordable Care Act (ACA) does little to address to address the monopoly problem and may even worsen it
- The ACA will entrench dominant incumbents, chill innovative start-ups, and encourage consolidation to increase market share
- We need better solutions to the chronic problem of too much concentration and too little competition in health care markets
- An expanded tool kit of pro-competitive policies should include:

  ✓ closer monitoring of emerging accountable care organization
  ✓ curbing new abuses of "state action" immunity
  ✓ challenging anticompetitive terms in insurer-provider contracts
  ✓ promoting interregional competition in health care services
  ✓ removing or limiting regulatory barriers to entry by new health sector competitors, and
  ✓ empowering consumers and private purchasers with better information tools

Thank you Chairman Goodlatte, Subcommittee Chairman Bachus, Committee Ranking Member Conyers, Subcommittee Ranking Member Cohen, and Members of the Subcommittee for the opportunity to testify today on health care consolidation and competition under the Affordable Care Act (ACA).

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations (including several years as co-editor of the *Washington Antitrust Report* at the Competitive Enterprise Institute).

All types of monopoly are not created equal in the U.S. economy. Health care providers with market power enjoy substantially more pricing freedom than monopolists in other markets.[1] Traditional antitrust enforcement tools have done little to halt extraordinary consolidation in local hospital markets over the last two decades, which drove higher price increases for inpatient services. Comprehensive, U.S.-style health insurance further enhances the pricing freedom of health care firms with market

power. The Affordable Care Act of 2010 (ACA) does little to address the monopoly problem and may even worsen it.

Problems of excessive concentration and insufficient competition in health care markets are not new, although their industry sector source has varied over time. For example, insurers were more dominant price-setters during the heyday of managed care in the 1990s. But more recently, markets for hospital services have presented the most serious competition policy issues. Havighurst and Richman observe that whereas monopolies in other parts of the economy enable sellers to charge higher prices while reducing output, comprehensive third-party health insurance coverage enables many cost-insensitive patients to pay monopolist providers' asking prices rather than being induced to give up desirable health care goods and services. Hence, it amplifies the redistributive effects of health care monopolies (lower-income premium payers subsidize upper-income providers and insurance consumers) and inflicts allocation inefficiencies as well.[2]

In other words, "too much of a good thing," at excessive prices. The combination of market concentration and generous insurance means consumers and providers end up overspending even more on costly health care. The combination of market concentration and generous insurance

means consumers and providers end up overspending even more on costly health care.

Competition policy in health care has been further hampered by judicial resistance to antitrust challenges to mergers involving nonprofit hospitals (which account for roughly three-quarters of hospital admissions, outpatient visits, and expenditures). Past cases have turned on skepticism by judges that local nonprofit hospitals would take advantage of their pricing power, and their belief that hospital monopolists would put to good use any market power they might possess. (As if nonprofit empire building never occurs!)

Effects of the ACA on Health Care Competition

A less-noted future problem in health care policy involves the increased "competition" among dominant market players to obtain, maintain, or extend their market power advantages. The highly regulated and heavily subsidized regime ahead under the ACA already has triggered a feverish scramble among health industry firms (insurers, pharmaceutical manufacturers, physician practice groups, and device makers, as well as hospitals) to get bigger market share and also become better "connected" politically to ensure that they will be among the politically dependent survivor incumbents in the years ahead. With most of the key decisions in

health care financing, coverage, and even treatment likely to be made in Washington, investments in winning future rounds of political competition is likely to trump responsiveness to market competition. Heavily regulated health care providers and insurers increasingly will have to focus more on dealing with the mandates, rules, and payment incentives of their main "customers" – government administrators, and less on the needs and wants of their patients and other private payers.

Hence, we have seen even more health care marketplace consolidation since passage of the ACA. To be sure, most of the consolidation in hospital markets occurred during the "merger wave" of the mid-1990s. But the more important policy question today is whether the ACA has made a bad problem *worse*. The primary effect of the law and its increasingly dense web of regulation has been to encourage a substantial increase in vertical integration and consolidation of health care services; mostly in the form of acquisitions of physician practices by hospitals.

As my AEI colleague Scott Gottlieb pointed out last year in testimony before this subcommittee, the trend toward physicians working as salaried employees has accelerated in recent post-ACA-enactment years. The majority of those physician employment contracts (and related

arrangements) are with hospitals. Insurers have largely been trying to play a catch-up game in tightening contractual links to physicians.

The more sanguine view of this trend among ACA advocates is that it represents overdue efforts to better integrate and coordinate health care delivery, in response to the law's new payment incentives (e.g., accountable care organizations, bundled payments, electronic health records adoption, value-based reimbursement). Such increased vertical, and even horizontal, consolidation potentially could improve the allocation of health care resources through less duplication, improved transitions between sites of care, reduced hospital readmissions, and better information sharing. But it also risks coming into conflict with pro-competition policies favoring greater price transparency, improved quality reporting, and lower prices.[3] Well-integrated health provider networks, or health systems, may face less competition, lock in patients to non-interoperable health IT systems, and leverage market power across health services domains.[4]

One strong factor in the move toward greater consolidation of health care services – particularly between hospitals and physicians – is the continued likelihood of tighter reimbursement limits combined with cost-increasing mandates that would shift more financial risk to providers. More physicians are selling their small practices, shedding business costs, and

seeking the "shelter" of salaried arrangements with hospitals or larger physician groups. On the other end of these transactions, hospitals and physician groups that can accumulate more capital, acquire in-demand practitioners, and increase patient referrals may be tempted to gain undue market power, demand higher rates, and increase health care costs; instead of just becoming more efficient and delivering higher value care.

Thus far, those who are skeptical of such pro-competitive consolidation have past history on their side.

On the health insurance side of the market, post-ACA-enactment consolidation has not been as rapid, thus far. However, longer-term factors suggest that this is likely to change. The new health exchanges, recently relabeled "marketplaces" (without market prices!), are structured to gravitate toward more standardized corridors of coverage. They are based on a limited set of actuarial-value tiers, cost-sharing limits, and bureaucratic pre-approval; then reinforced by a broader insurance regulatory scheme of mandatory essential health benefits, first-dollar coverage of preventive services, premium rate review, new medical loss ratio (MLR) ceilings on insurers' profits and administrative costs, and a thickening web of additional "guidance."

For example, the minimum MLR rules for insurers may superficially appeal to some insurance purchasers, but they could further disarm payers in aggressive price negotiations with providers and stifle insurers' investments in innovative monitoring and improvement of health care delivery.[5] MLR rules also could inhibit new entry by start-up insurance carriers lacking sufficient investment capital cushions to overcome initial marketing and administrative expenses. The eventual scope and scale of the ACA's regulatory requirements for essential health benefits also could discourage investments in low-cost, nonmedical alternative interventions that can produce results superior to mandated traditional care.

It is important to distinguish between short-term effects as the ACA exchanges begin their first shake-down year of implementation and the more likely long-term dynamics of this more heavily regulated and tax-subsidized "market" for individual and small-group insurance. Given the potential leverage that state and federal exchange administrators may eventually exercise over participating insurers,[6] the most likely scenario to unfold as the costs of guaranteed benefits squeeze against the supply of revenue from tax subsidies and enrollees' discounted premiums is for a few surviving large insurers to gain a dominant share of the coverage provided in the exchanges, as they gravitate more toward a regulated public utility model

(e.g., captive customers, low but predictable rates of return, economies of scale in managing regulatory compliance costs, and commodity-like products). Whether this dynamic might eventually spill over into the larger employer-based health insurance market remains conjectural, but not implausible, at this point.

Larger Problems:

Health Firms Grow Bigger & Politics Reigns Supreme

Passage of the ACA triggered a new wave of defensive consolidation in the health care sector, instead of just presenting better opportunities to reconfigure operations and business relationships to become more efficient. Anticompetitive strategies were predictable responses to the new law's incentives and penalties. The elegant theory of how the ACA's payment incentives and regulatory guidance will inspire more coordinated, high-value care within larger, more vertically integrated health care systems needs to be tempered by some more likely political and economic realities.

Entrenching Dominant Incumbents

The ACA's reimbursement schemes and regulatory burdens are more likely to entrench large, existing players in health care markets than to encourage start-up innovators. The law is designed to limit returns on private capital invested in health care services and products; indeed it often frames

private profits as reducing the resources needed for direct patient care (e.g., rate review thresholds, MLR limits, formulaic "productivity adjustments" in reimbursement, rebate-like taxes on health care providers, insurance cooperative subsidies, and mandated benefits). However, these very rules bias the evolving health system further against entry by the new, innovative entrepreneurs most likely to search for hyper-profitable new ways to reengineer inefficient health care practices, products, and systems.

Under the ACA's regime of complex, confusing, and costly regulation, it will take a larger village of lawyers, lobbyists, and lines of credit to comprehend, cope, and comply (or maneuver).[7] Growing bigger, or staying large, becomes the best hedge against political and regulatory risks. Too big to fail may not be guaranteed, but too small to survive becomes more likely.

The evolving regulatory balance, of course, remains unsteady and not fully charted. Possible settings could range all the way from eventual "capture" and protectionism for the largest producers that last longest at the bargaining table, to gains from trade in political markets to override economic ones, and to the most likely one in this case – symbiosis. Although some symbiotic relationships (obligate ones) require both parties to depend entirely on each other for survival, more "parasitic" ones benefit one party

while the other is harmed. It remains to be seen whether the government side of the ACA relationship with the health industry can succeed instead in achieving ectosymbiosis, in which it lives on its junior partners in the health industry, or even "inside" of them.[8]

Market Imperfection vs. Government Failure

Most apologists for a heavier role for government intervention in health care usually begin by asserting that "health care is special" and its markets inevitably are riddled with imperfections that justify greater regulation. Yet health policy in the U.S. has spent decades trying to implement such corrective strategies, with a mounting record of *government failure*. Excessive levels of third-party payment, lack of price transparency, barriers to entry, opaque cross-subsidies, unsustainable unfunded liabilities in health entitlement programs, rewarding volume rather than value, lagging adoption of information technology, excessive reimbursement and inadequate reimbursement – these are arguably greater reflections of flawed public policy more than of malfunctioning private markets.

The two sectors of the U.S. economy traditionally plagued by rising costs, uneven quality, poor value, and disparities for decades have been health care, and primary and secondary education – the two most heavily regulated and publicly subsidized ones. Yet the next doses of stronger

government-centric remedies are always promised to work better than the last ones.

For example, the ACA promises that Medicare should lead the way to innovative health care delivery reform. Meanwhile, it remains a predominantly fragmented, fee-for-service system that has reimbursed providers for greater volume of services rather than higher quality and better outcomes; sets thousands of administered payments that distort prices elsewhere; saddles younger and future generations with crushing unfunded liabilities; and launches dozens of demonstration projects designed to be "inconclusive." But it keeps the HHS inspector general's staff busy tallying large estimated amounts of fraudulent and improper payments.

Yes, Medicare is such a dominant influence across the health care sector that it really does have to help lead the way to better performing care delivery. It just hasn't done much of that thus far.

ACA advocates warn that providing too many health care choices in private markets will cause information overload for hapless consumers, who need a handful of more standardized price, coverage, and treatment options. Evidently, similar mental processing constraints do not apply to purchasers or providers facing tens of thousands of pages of often late-arriving and shape-shifting new regulatory guidance under the ACA.

This Time Is Different?

Antitrust enforcers should be congratulated for recently ending their long losing streak in the courts in challenging hospital mergers seemingly likely to reduce competition and raise prices. But prospects for addressing competition problems in the ACA-era of health care markets through conventional antitrust enforcement remain limited. Rolling back previous hospital mergers is quite difficult legally, impractical administratively, and often counterproductive economically. The hospital consolidation horse not only left the barn several decades ago; it's taken several laps around the track.

In any case, application of pro-consumer-welfare antitrust policy enforcement has a spotty record and it remains more of a late-20th-Century development. Indeed, just about any sorts of effective antitrust constraints on medical practitioners were virtually unprecedented until the exemption for "learned professionals" began to erode in the mid-1970s.[9] Moreover, antitrust law often applies its rules of health care competition differently for market participants than for government regulators and policymakers. Administered prices and rate setting represent business as usual for the latter, whereas price-fixing by private parties is per se illegal. The "state action" doctrine not only authorizes regulatory constraints on market

competition; it may encourage private special interest groups to stretch its boundaries and provide cover for their anticompetitive strategies.[10] In the political arena, *Noerr-Pennington* immunity applies to actions where private individuals seek anticompetitive action from the government (short of "sham" litigation) which might otherwise violate federal antitrust laws.[11]

The Search for More Effective Policy Solutions

The better version of antitrust policy still has an important role to play in ensuring more competitive health care practices. We need better solutions to the chronic problems of too much concentration and too little competition. Beyond tighter review of new hospital mergers and consolidations, they should include:

- Curbing new abuses of "state action" immunity,
- Challenging anticompetitive terms in insurer-provider contracts,
- Requiring unbundling of monopolized health care services,
- Promoting interregional competition in health care services, and
- Removing or limiting regulatory barriers to entry by new health sector competitors,
- Ensuring that new accountable care organizations deliver on their promises rather than facilitate aggregation and abuse of market power, and

- Empowering consumers and private purchasers with better information tools.

The longstanding state action immunity doctrine, which essentially allows state regulation to immunize otherwise anticompetitive (and illegal) private conduct, needs to be tightened. Although the Supreme Court appeared to make progress on this front earlier this year in a case from Georgia,[12] subsequent legal developments appear to have hampered the shaping of an effective remedy.

One troublesome practice in insurer-provider contracts is for a dominant health care provider-seller to promise to give an insurer-buyer the same discount from its high prices it might give to a competing health plan. Such most-favored-nation (MFN) clauses can play a useful role in many commercial contracts, but they have been prone to anticompetitive abuse in certain highly concentrated health care markets recently (most notably in Massachusetts and Michigan). When MFN clauses protect insurers against their competitors' getting better deals, many of those insurers can become too likely to give in quickly to extortionate monopolist price demands. Regulators have a necessary role in distinguishing better between restrictive agreements that achieve transactional efficiencies and agreements that

restrict insurers' freedom to cut self-serving price deals with competitors. Other anticompetitive contractual practices worthy of closer regulatory scrutiny involve "anti-steering provisions" and "must include in network" guarantees.

Another promising antitrust enforcement step suggested by Richman and Havighurst could be to require hospitals and other provider entities to unbundle, at a purchaser's request, certain health care services so that the purchaser can negotiate their prices separately. They note that permitting a hospital monopolist to tie unrelated services together expands its reach, profitability, and longevity - at the expense of consumer welfare. Drawing the exact lines for when and how to exercise this "unbundling" enhancement of anti-tying antitrust enforcement needs further work (such as where to set market concentration thresholds for its application), but it is worthy of consideration for improved price competition.

A different mechanism to battle local monopolies in health care would involve expanding the locus of competition. Future health policy should strive to encourage, not inhibit, interregional competition by reducing regulatory and reimbursement barriers to both domestic and international versions of "medical tourism."[13] Other “market opening” supply-side policies should extend to revision of scope of practice restrictions at the state

level and reconsideration of current limits on expansion of physician-owned hospitals.

An important target for careful antitrust scrutiny involves the emergence of politically favored accountable care organizations (ACOs). Although promoted by the Obama administration as one of its magic bullets to reform our inefficient delivery system and reduce its projected future costs, ACOs could instead mutate into new vehicles to engineer and leverage greater monopoly power in already-concentrated health provider markets. The regulatory framework to govern ACOs has been revised since its initial incarnation but still needs to be monitored closely to ensure that promised efficiencies in health care coordination and integration are more likely to outweigh the danger of even further consolidation of provider market power, and that such organizations remain truly accountable to patients and market forces (and not just to political patrons).

Finally, we should remember that information is power within health care markets. The June 2011 report by the Attorney General of Massachusetts on "Health Care Cost Trends and Cost Drivers" in the state noted the following: Its health care markets lacked transparency in price and quality information. Variation in prices was not correlated to the methodology used to pay for health care services (risk sharing versus fee for

service). Globally paid providers did not have consistently lower total medical expenses. The report emphasized that health care markets must be responsive to the “purchaser” (i.e., consumers and employers), armed with necessary incentives and information.[14]

The ACA promises to enhance and expand health information, but it relies more on measurement and dissemination through government-mediated, centralized channels, rather than a more pluralistic market-based competition to discover, refine, and deliver it. Expansion of all-payer claims data bases, outcome-based performance measurement, and wider access to Medicare claims data for qualified entities may help on the supply side, but , the ACA’s complex cross-subsidies, administered prices, and rating restrictions are likely to suppress necessary information about the full costs of health care services and discourage consumers’ incentives to seek it.

Instead of doubling down on the "metabolic eating disorder" triggered by public policies that have encouraged overconsumption of conventional, highly subsidized health insurance -- or resorting to tighter price controls and public-utility-style regulation of politically mandated coverage, we should consider some better remedial medicine - a stronger dose of market competition.

Notes

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[1] Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions* (Washington, DC: American Enterprise Institute, June 2012), 4-7.
[2] Clark C. Havighurst and Barak D. Richman, "Distributive Injustice(s) in American Health Care," *Law & Contemp. Probs,* Autumn 2006.
[3] Katherine Baicker and Helen Levy, "Coordination versus Competition in Health Care Reform," *New England Journal of Medicine* 369 (9): 789-791.
[4] Ibid.
[5] Scott E. Harrington, "Medical Loss Ratio Regulation under the Affordable Care Act," *Inquiry* 50: 9-26; Scott E. Harrington. *Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition* (Washington, DC: American Enterprise Institute, December 2010).
[6] See, for example, Henry J. Aaron and Kevin W. Lucia, "Only the Beginning – What's Next at the Health Insurance Exchanges?" *New England Journal of Medicine* (online first, September 4, 2013), www.nejm.org/doi/full/10.1056/NEJMp1308032?query=TOC.
[7] See Sheryl G. Stolberg, "Reaping Profit After Assisting on Health Law," *New York Times,* September 18, 2013, A1.
[8] "Symbiosis," *Wikipedia*, en.wikipedia.org/wiki/Symbiosis.
[9] See *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).
[10] See Richman, 2012, at 11-13.
[11] See, for example, *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965); and *California Motor Transport Co. v. Trucking* Unlimited, 404 U.S. 508 (1972).
[12] *Federal Trade Commission v. Phoebe Putney Health System, Inc. et al.*, 568 US __ (2013), www.supremecourt.gov/opinions/12pdf/11-1160_1824.pdf March
[13] Richman, 2012, at 15-16, 18; Aaditya Mattoo and Randeep Rathindran, "How Health Insurance Inhibits Trade in Health Care," *Health Affairs* 25(2): 358-368.
[14] Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA: June 22, 2011).

Mr. BACHUS. I thank you.

Now, our next two witnesses have been waiting patiently to respond I guess. Mr. Cohen and our Democratic Members here invited them. Are you all raring to go? Professor Greaney, you are up next.

TESTIMONY OF THOMAS L. GREANEY, CHESTER A. MYERS PROFESSOR OF LAW, SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Mr. GREANEY. Thank you, Chairman Bachus and Members of the Committee. I think you will find my diagnosis is a bit different than Mr. Miller's but I think our prescriptions for the remedy are pretty much the same.

Let me summarize my testimony with five key points.

First of all, the Affordable Care Act actually depends upon and promotes competition in provider and payer markets.

Secondly, hospital market concentration is the result of merger waves that have been going on for the last 20 years. And this consolidation was actually fomented by what I believe are erroneous Federal court decisions, lax antitrust enforcement, and was exacerbated by Government payment policies and other laws.

Third, as to provider consolidations, the Affordable Care Act fosters pro-competitive consolidations through reforms and incentives and encourages providers to form efficient delivery systems. But I think it is erroneous and misleading to claim the Affordable Care Act is somehow responsible for anticompetitive mergers when in fact these mergers are designed precisely to avoid the pro-competitive features of the act.

Fourth, there has been a significant resurgence in antitrust enforcement, and I think that should serve to limit consolidations going forward. But as other witnesses have said, antitrust will not unwind pre-existing consolidations.

The fifth point in my testimony is much on track with what you have heard from Professor Richman. What he and I both call the provider monopoly problem calls for countermeasures, countermeasures that reduce barriers to entry, enable payers to develop tools that promote consumer choice, and encourage new delivery systems.

So let me take these one at a time. First, beginning with the proposition I began with, that the Affordable Care Act both depends on and promotes competition, the natural question to ask is why you need the Government to make health care markets more competitive. And the answer in my testimony is what I call the "witches' broth of history," provider dominance, ill-conceived payment systems, and most importantly, the market characteristics of health care which make markets different in health care.

And as a result, we found ourselves at the beginning of the century with the worst of two worlds. We had fragmentation on the one hand, doctors operating in silos, practices of onesies and twosies unconnected to each other and providing duplicative care that is not evidence-based. At the same time, we had growing pockets of concentration, dominant hospitals and dominant specialty practices that were able to charge monopoly prices.

My testimony details some of the specifics about how the ACA's numerous efforts to reform both private and governmental insurance payments create marketplaces for people to shop and compare plans, and undue existing obstacles will make markets work maybe for the first time. And I can go into some detail about some of the Medicare reforms that I think are important and pro-competitive and without which markets will not work.

Next, a couple of points briefly on the provider monopoly problem.

First, provider monopolies is not just a problem for the Affordable Care Act. It is a problem for those who would rely on laissez-faire approaches to health care, for those who would propose vouchers for Medicare. Provider market power has been shown through the countless studies that Professor Richman and I cite as a primary culprit in increasing costs today, prices rising as much as 40 percent after hospital mergers.

The good news I mentioned in my testimony was the resurgence of antitrust enforcement with the Government agencies, coupled with many, many of the State Attorneys General challenging hospital mergers. An important case goes to trial on Monday challenging physician acquisitions by a hospital in Idaho. And also going after practices such as most favored nations clauses and other discriminatory practices that harm competition. And finally, the FTC has done an admirable job of competition advocacy, urging State legislatures to avoid legislation that is anticompetitive.

But now, the caveat I offered earlier. Antitrust has little to say about extant market power, power that is already there lawfully acquired. There is no silver bullet, but my testimony points to several kinds of actions that could be taken. These are, to be sure, legislative and regulatory but they are pro-competitive regulations and statutes.

Just very quickly, dealing with the certificate of need, which in many States creates a barrier to entry, excessive restrictions that have been imposed by the Affordable Care Act on physician-controlled specialty hospitals and State laws that may impair quick clinics and things like that, these are the sources of new entry into the dominant markets that may at least provide a relief valve.

In addition, we could expand the opportunities for mid-level professionals through State law changes that would allow them to practice within the full scope of their professional license. This move would serve to help new organizational arrangements like patient-centered medical homes and ACO's provide a counterweight in the dominant markets.

The second set of remedies goes to things that might strengthen employers' and payers' ability and willingness to negotiate effectively in the face of provider market power. Some of the ideas that both Professor Richman and I have talked about deal with laws that might abolish most favored nations clauses, as Michigan did in response to the Justice Department's suit there, doing away with contractual commitments to prevent insurers from using tiering and other things that may at least allow consumers to undercut the monopoly power in these markets. Laws affecting price transparency can help and enlist consumers in the effort. And finally, calling upon the expertise and leverage of the agencies and the in-

surance regulators to back up or nudge payers that face monopolies. And State insurance commissioners and exchanges can require or at least encourage the unbundling of services, as Professor Richman suggests, but also do other things to insist on dealing with market power.

Let me close with just a cautionary note. These ideas I have outlined are competition-enhancing regulations and laws designed to address the provider monopoly problem. If those do not work, the last resort, if all options fail, will be public utility-style regulation. That is what most economists predict for dominant monopolies such as all payer rate controls or empowering insurance commissioners to place caps on their expensive provider contracts.

Thank you very much.

[The prepared statement of Mr. Greaney follows:]

Prepared Statement of
Professor Thomas L. Greaney

Before the

Committee on the Judiciary
United States House of Representatives

Subcommittee on Regulatory Reform, Commercial and Antitrust Law
on
"The Patient Protection and Affordable Care Act and the Consequent Impact on Competition in Healthcare"

September 19, 2013

Chairman Goodlatte, Subcommittee Chairman Bachus, Committee Ranking Member Conyers, Subcommittee Ranking Member Cohen and Members of the Subcommittee, I much appreciate the opportunity to testify on the important issue of health care consolidation and competition policy in the context of health reform. By way of introduction, I am the Chester A. Myers Professor of Law and Director of the Center for Health Law Studies at Saint Louis University School of Law. I have devoted most of my 26-year academic career to studying issues related to competition and regulation in the health care sector, writing numerous articles on the subject and co-authoring the leading casebook in health law. Before that I served as Assistant Chief in the Antitrust Division of the United States Department of Justice, litigating and supervising cases involving health care. My professional affiliations include membership in the American Health Lawyers Associations and I serve on the Advisory Board of the American Antitrust Institute.

Let me summarize the key points of my analysis of the market concentration problem:

- The Affordable Care Act depends on and promotes competition in provider and payor markets.
- The current extent of hospital market concentration is the result of various "merger waves" over the last twenty years facilitated by erroneous court decisions and lax antitrust enforcement, and exacerbated by government policies.
- There is a broad consensus among economists and health policy experts that concentration in provider markets is a major driver of higher prices in health care and is associated with wide variations in payment and quality around the country.
- It would be erroneous to claim that the Affordable Care Act is somehow responsible for anticompetitive consolidation when in fact such mergers and joint ventures are efforts to *avoid* the procompetitive aspects of the Act.
- The Affordable Care Act encourages procompetitive consolidations through payment reforms and incentives to form efficient delivery systems which have begun to flourish, such as accountable care organizations and patient-centered medical homes.
- The resurgence in antitrust law enforcement should limit future increases in concentration and curb the exercise of market power, but will not unwind most prior consolidations.
- The problem posed by extant provider monopolies lends support for countermeasures including Medicare reimbursement reforms, reducing barriers to entry, and other forms of pro-competition regulation.

Competition Policy and the Affordable Care Act

I'd like to begin with an important proposition that is sometimes lost in the rhetoric about health reform. The Affordable Care Act both *depends on* and *promotes* competition in provider and insurance markets. A key point is that the new law does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public.

Why do we need government intervention to make health care markets perform more efficiently? The answer lies in a witches' broth of history, provider dominance, ill-conceived government payment and regulatory policies, and perhaps most importantly, market imperfections that are endemic to delivery of services, insurance, and third party payment. Justification for regulation to promote competition can be found in virtually every economic analysis of health care. Markets for providing and financing care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly and selection in insurance markets that greatly distort markets. Add to that governmental failures—payment systems that reward intensity and volume, but not accountability for resources or outcomes; restrictions on referrals that impede efficient cooperation among providers; and entry impediments in the form of licensure and CON, to name a few. Finally, toss in a strain of professional norms that are highly resistant to marketplace incentives—and you have the root causes of our broken system.

Looking at the result in health care markets, we find the worst of two worlds: *both* fragmentation and concentration. As I'll discuss in a minute, hospital and specialty provider markets are highly concentrated while most primary care physicians have historically operated in "silos" of solo or small practice groups. In most places, there is scant "vertical integration" among providers of different services—a phenomenon that impedes effective bargaining to reduce costs and prevent overutilization of services, and also has adverse effects on the quality of health services patients receive because it inhibits coordination of care.

The Affordable Care Act tackles these problems on many fronts. My article, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*,[1] describes these measures in some detail, but I will focus on a few of the most important. Although it may be counterintuitive to those who dichotomize between competition and regulation, law can *foster* competition by imposing rules and standards, and even by mandating purchasing or creating competition-

[1] Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 Or. L. Rev. 811 (2011).

enabling institutions. As I have argued since the early days of the "competitive revolution" in health care, this kind of regulation is a condition precedent for effective markets.[2]

To briefly recap some of the ACA's competition-improving steps:

First, a centerpiece of reform is the Health Insurance Exchange. At bottom, exchanges are really just efficient markets for offering and purchasing health insurance analogous to farmers markets or travel websites. The ACA adopts regulations that are necessary to make insurance products comparable and understandable, that require basic minimums of coverage, and that protect against the insurance industry's long-standing practice of chasing down only good risks—all textbook efforts to make competition work efficiently in the insurance market.

Second, Medicare payment and delivery reform plays a critical—and generally unappreciated—role in promoting competitive markets, both private and public. Underlying the myriad changes in payment policy and the ACA's pilot programs and other innovations, such as value-based purchasing, accountable care organizations and reforms to bidding in the Medicare Advantage program, is the understanding that Medicare policy strongly influences the private sector. Private payors often follow Medicare's lead on payment methods and depend on the program to set quality standards. Moreover, the incentives it creates in the way medicine is delivered has unquestioned spillover effects on commercial health plans. Most notable in this regard are the prodigious efforts undertaken by the ACA to redirect federal payment *away* from fee-for-service payment.

Third, the ACA seeks to create incentives for providers to develop innovative organizational structures that can respond to payment mechanisms that rely on competition to drive cost containment and quality improvement. The watchword here is *integration*. Congress recognized that it was essential to stimulate formation of organizations that could receive and distribute reimbursement and be responsible for the quality of care under the new payment arrangements contained in the ACA and developing in the private sector such as bundled payments and global reimbursements. Given the badly fragmented structure of health delivery, a critical innovation is the Medicare Shared Savings Program, which fosters development of Accountable Care Organizations to serve *both* Medicare beneficiaries and private payers and employers.

Finally, the new law deals with a very significant "public goods" market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. The Act does so by subsidizing research and creating new entities to support such research and to disseminate information about outcome and medically-effective treatments. Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies and add incentives to improve quality by using "evidence based medicine."

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[2] *See* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 Yale. J. on Reg. 179 (1988) (predicting that competition in health care would not succeed if regulation and infrastructure do not support it).

The important take-away is that much of the extensive regulation contained in the new law is explicitly designed to promote competition. It aims to encourage the redesign of payment and delivery systems so that private payers and providers can interact in the marketplace to provide the best mix of cost and quality in health care. As I'll discuss in a moment, however, there are obstacles to realizing the potential benefits of the competitive strategy for health care reform.

Concentration and Antitrust Enforcement

So, what could possibly go wrong? Many observers, including myself, have pointed to the extensive concentration that pervades health care markets and constitute a serious impediment to effective competition. It is important however to put this phenomenon into context—both as to how it came about and what can be done about it.

First, it should be understood that although we have experienced a "merger wave" in recent years, it is not the first, nor is it responsible for the widespread concentration we see in many markets today. Hospital consolidation has proceeded in spurts several times over the past twenty years, with the biggest wave occurring in the mid-1990s. The Robert Woods Johnson Foundation Synthesis Project analysis summarized this phenomenon:

> In 1990, the typical person living in a metropolitan statistical area (MSA) faced a concentrated hospital market with an HHI [the index of concentration used in antitrust cases] of 1,576. By 2003, however, the typical MSA resident faced a hospital market with an HHI of 2,323. This change is equivalent to a reduction from six to four competing local hospital systems.[3]

Notably, the largest number of hospital mergers was undertaken *after* the defeat of the Clinton Health Reform proposal and during a time when managed care was at its zenith. While academics disagree on what caused the sharp increase in mergers, recent studies suggest that hospitals' anticipation of increased cost pressures from managed care led them to consolidate. Moreover, one thing is clear: a series of unsuccessful antitrust challenges to hospital mergers in federal court gave a green light to consolidation. And, as the government antitrust agencies themselves admit, these decisions caused federal and state enforcers to back away from challenging hospital mergers for almost seven years.[4] Adding to this tale of misfortune is the widely-held opinion that the courts got it wrong: the majority of judicial decisions allowing

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[3] WILLIAM B. VOGT & ROBERT TOWN, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

[4] An Assistant Director of the FTC's Bureau of Competition acknowledged, "Both the FTC and the DOJ left the hospital merger business and determined that these cases were unwinnable in federal district court." Victoria Stagg Elliot, *FTC, in Turnabout, Takes a Closer Look at Hospital Mergers*, American Medical News (April 9, 2012), http://www.amednews.com/article/20120409/business/304099973/7/.

hospital mergers found unrealistically large geographic markets that did not conform with sound economic analysis.[5]

The result of this spike in hospital concentration was disastrous for the American public. A large body of literature documents the existence, scope and effects of market concentration. One well-regarded compilation of the numerous studies on this issue spells out the link between hospital market concentration and escalating costs of health insurance: hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.[6] Another important study, undertaken by the Massachusetts Attorney General, documents the effects of "provider leverage" on health care costs and insurance premiums, notably finding prices for health services are uncorrelated with quality, complexity, proportion of government patients, or academic status but instead are positively correlated with provider market power.[7] A leading economist summarized the impetus to merge with rivals in the face of pressure from payers to compete:

> I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.[8]

Provider concentration has a double effect—one in commercial markets, the second on government payers, especially Medicare. The most obvious effect, as described above, is to increase dominant providers' ability to command higher prices and resist efforts to limit unnecessary procedures. A second effect, often overlooked, is the cost-elevating impact of provider market concentration upon government payers. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, "when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise."[9] These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.

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[5] *See e.g.*, Cory S. Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 8216, 2001), *available at* http://www.nber.org/papers/w8216.

[6] VOGT & TOWN, *supra* note 3.

[7] MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B) (2010), *available at:* http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf. Compare with the 2011 and 2013 updates, available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf and http://www.mass.gov/anf/docs/hpc/ag-presentation.pdf, respectively.

[8] DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 122 (2000).

[9] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM xiv (2009), *available at* http://www.medpac .gov/documents/mar09_entirereport.pdf.

The key point to be derived from the past twenty years of experience with hospital consolidation is that, if not checked by vigilant antitrust enforcement, it can undermine the benefits that competition offers. Further, mergers that concentrate local markets have largely been driven by a desire to gain bargaining leverage. (It is important to note of course that not all consolidation is harmful: many hospital mergers do not affect local markets as they substitute a stronger, more efficient owner not currently competing in the market or they involve relatively small competitors in the same market.) In sum, it would be highly misleading to suggest that the Affordable Care Act is somehow responsible for a new wave of attempted anticompetitive provider mergers, when in fact those mergers are an effort to *avoid* the very pro-competitive policies the new puts in place.

Turning to the payer side, health insurance markets have a long history of consolidation and increasing concentration in the individual and small group market, where, according to some data, two firms have greater than fifty percent of the market in twenty-two states, and one firm has more than fifty percent in seventeen states.[10] The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private insurance revenue increased even faster than medical costs; economists at the Urban Institute concluded that "the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time."[11] While some studies question the extent of insurers' exercise of market power, bilateral market power is unlikely to serve consumer interests. Finally, experience suggests that entry into concentrated insurance markets is far from easy and may be unlikely to occur in markets with few insurers. A recent study by the Antitrust Division of the Department of Justice found that entry in such insurance markets was impeded by the difficulty of securing provider contracts.[12] Congress addressed the problem in several ways: encouraging formation of new competition via nonprofit insurance cooperatives and multi-state health plans. Although the proposal to include a public option plan in every market was rejected, by improving insurance markets, reducing risks of adverse selection, and establishing health insurance exchanges, the ACA took steps designed to induce de novo entry into concentrated insurance markets.

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[10] KAREN DAVENPORT & SONIA SEKHAR, CTR. FOR AM. PROGRESS, *Insurance Market Concentration Creates Fewer Choices: A Look at Health Care Competition in the States* (Nov. 5, 2009), *available at* http://www.americanprogress.org/wp-content/uploads/issues/2009/11/pdf/health_competition_1109.pdf.

[11] JOHN HOLAHAN & LINDA BLUMBERG, URBAN INST., HEALTH POLICY CTR., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH CARE REFORM? 3 (2008), *available at* http://www.urban.org/UploadedPDF/411762_public_insurance.pdf.

[12] The Department of Justice's study concluded:

> [T]he biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Christine A. Varney, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, *Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust and Healthcare Conference*, May 24, 2010, *available at* http://www.justice.gov/atr/public/speeches/258898.pdf.

The Resurgence of Antitrust Enforcement

In recent years the Federal Trade Commission, the Antitrust Division, and a number of State Attorneys General have stepped up antitrust enforcement. The federal antitrust agencies' cases, along with competition advocacy in the legislative and regulatory arenas, have focused on (1) stopping anticompetitive mergers, (2) challenging the exercise of market power by dominant providers and insurers, (3) urging legislators to reject or remove barriers to competition or legislative exemptions from the antitrust laws, and (4) attacking competitor collusion, most notably between manufacturers of branded pharmaceuticals and generic entrants and provider collusion in managed care negotiations. In addition, state attorneys general and private litigants have brought a number of important antitrust cases principally in the merger area.[13]

These cases and legislative comments constitute a significant and necessary step toward protecting the competitive policies that undergird the Affordable Care Act. In the merger area, for example, the FTC has challenged four highly concentrative hospital mergers in the last three years.[14] Further, in an important case decided last year, the Supreme Court overturned the lower court's interpretation of the state action doctrine which it found erroneously shielded a hospital merger to monopoly.[15] Notably, the FTC and state attorneys general have also investigated and challenged mergers of physician practices and acquisitions of physician practices by hospitals.[16] The Department of Justice challenged, and settled by consent decree requiring divestitures, a merger of health insurers that would reduce competition in Medicare Advantage contracting[17] and forced another health plan to abandon its plan to acquire its

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[13] Because my testimony today focuses on provider and payor competition, I am omitting what is undoubtedly the most significant antitrust enforcement effort in health care: the challenge to pay-for-delay agreements in the pharmaceutical sector. The Supreme Court's decision in *FTC v. Actavis, Inc. et al.*, cleared the way for future challenges to the agreements that divide markets for pharmaceutical products, an activity that is estimated to involve costs of $3.5 billion per year. 570 U.S. ___ (2013).

[14] *In the Matter of* OSF Healthcare System, and Rockford Health System, No. 111-0102, F.T.C. Docket No. 9349, (F.T.C. April 13, 2012) (dismissed upon merger abandonment), *available at* http://www.ftc.gov/os/adjpro/d9349/120413rockfordorder.pdf; *In the Matter of* ProMedica Health System, Inc., No. 111-0167, F.T.C. Docket No. 9346 (F.T.C. March 28, 2012) (petition for review on file with 6th Circuit, No. 12-3104), *available at* http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf; *In the Matter of* Reading Health System and Surgical Institute of Reading, No. 121-0155, F.T.C. Docket No. 9353 (F.T.C. Dec. 7, 2012) (dismissed upon acquisition abandonment), *available at* http://www.ftc.gov/os/adjpro/d9353/121116readingsurgicalempt.pdf; FTC v. Phoebe Putney Health System, Inc., 568 U.S. ___ (2013).

[15] *Id.* (holding that because Georgia has not clearly articulated and affirmatively expressed a policy allowing hospital authorities to make acquisitions that substantially reduce competition, state-action immunity does not apply).

[16] *See* Complaint for Permanent Injunction, FTC and State of Idaho, Plaintiffs, v. St. Luke's Health System, Ltd, and Saltzer Medical Group, P.A., No. 1:12-cv-00560-BLW-REB (D. Idaho March 12, 2013); Press Release, FTC Bureau of Competition Director Richard Feinstein, Feinstein Statement on Providence Health & Services' Abandonment of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest (April 8, 2011), http://www.ftc.gov/opa/2011/04/providence.shtm. *See also In the Matter of* Renown Health, No. 111-0101, F.T.C. Docket No. C-4366 (F.T.C. Dec. 4, 2012) (settled by consent agreement), *available at* http://www.ftc.gov/os/caselist/1110101/121204renownhealthdo.pdf.

[17] Order, United States v. Humana Inc. and Arcadian Management Services, Inc., No. 1:12-cv-00464-RBW (D.D.C. March 28, 2012), *available at* http://www.justice.gov/atr/cases/f291400/291486.pdf.

leading rival.[18] Together these cases should send a strong signal that consolidations will be closely scrutinized.

A second series of cases involve challenges to the actions of dominant providers or dominant payers. These cases represent a marked departure from the posture of the agencies over the last two decades in which the government agencies have rarely taken on cases of monopolization or abuse of dominant position. The conduct at issue involves a variety of "exclusionary" actions: vertical arrangements that foreclose rivals without significant efficiency justifications. For example, the Antitrust Division challenged a dominant insurer's insistence on "most favored nations" clauses from contracting hospitals that severely disadvantaged rival insurers.[19] This case was dismissed after the Michigan legislature essentially agreed that MFNs were harmful to competition and prohibited their use in health care contracts.[20] In another case, settled by consent decree, the Division challenged a near-monopoly hospital's demands for exclusionary discounts from insurers.[21]

Preserving the Potentially Pro-competitive Effects of Accountable Care Organizations

Of the many important innovations contained in the Affordable Care Act, the Medicare Shared Savings Program (MSSP), which promotes the development of accountable care organizations, has undoubtedly garnered the most attention. The ACO strategy takes direct aim at the twin problems of the health care system: fragmented delivery and payments that reward volume rather than performance. Because they will be accountable for the full range of care needed by beneficiaries, ACOs need to establish integrated networks of providers that can monitor quality and provide seamless, cost-effective care. The Affordable Care Act explicitly encourages Medicare ACOs to also serve the commercially-insured sector and self-funded employers.

From the standpoint of competition policy, ACOs offer an important opportunity for providers to align in entities capable of delivering care that consumers (employers, insurers and individuals) can compare and negotiate with to get the best bargain in price and quality. Thus *both* provider integration and rivalry are key to the success of the concept. CMS, the FTC and the Department of Justice have worked closely together to establish guidelines[22] that will help

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[18] Press Release, U.S. Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (Mar. 8, 2010), http://www.justice.gov/atr/public/press_releases/2010/256259.pdf.

[19] Complaint, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010), *available at* http://www.justice.gov/atr/cases/f263200/263235.pdf. *See also* Press Release, U.S. Dep't of Justice, Justice Department Files Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan (Oct. 18, 2010), http://www.justice.gov/atr/public/press_releases/2010/256259.pdf .

[20] Press Release, *supra* note 18. *See also* Stipulated Motion and Brief to Dismiss without Prejudice, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-14155-DPH-MKM (E.D. Mich. March 25, 2013), *available at* http://www.justice.gov/atr/cases/f295100/295119.pdf.

[21] Final Judgment, United States v. United Regional Health Care System, No. 7:11-cv-00030-O (N.D. Tex. Sep. 29, 2012), *available at* http://www.justice.gov/atr/cases/unitedregional.html.

[22] Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (October 28, 2011).

providers assess the antitrust boundaries when forming ACOs. By some estimates there are over 488 ACOs operating in all 50 states, over 250 of which are participating in the Medicare Shared Savings and Pioneer programs.[23]

Several procompetitive aspects of the agencies' regulations and policy statements should be noted. First, the MSSP allows ACOs considerable flexibility in the way they organize themselves. ACOs may be formed by joint ventures among providers and exclusive contracting is permitted only to the extent it does not impair competition. Exceptions are established for rural providers that recognize the special competitive circumstances they face. Dominant providers are constrained to some extent and cautioned about specific practices that interfere with payers' ability to engage in competitive contracting. Finally, CMS will gather data and monitor carefully the performance of participating ACOs.

There are, to be sure, legitimate concerns that ACOs may form in a manner that allows providers to aggregate market power that can be exercised over private health plans and employers. At the same time, ACOs offer a distinct opportunity to increase the competitiveness (and hence the quality and cost-effectiveness) of the delivery system. The antitrust agencies and CMS appear to have set out a framework capable of monitoring the competitive implications of ACOs as they develop.

Addressing the Provider Concentration Problem

While the antitrust agencies' efforts to promote and protect competition in health care markets is commendable, it is also the case that antitrust law has little to say about monopolies lawfully acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in many hospital markets and a growing number of physician specialty markets, it is particularly important to encourage other measures that promote competition. Pro-active, pro-competition governmental interventions may be needed.

Although there is no single "silver bullet" to solve the problem posed by extant provider concentration, there are a number of steps that reduce the market power exercised in such markets.[24] To begin with, laws that impose barriers to entry should be amended or repealed. For example, hospital concentration may be lowered in some states by eliminating government-imposed barriers to entry such as Certificate of Need laws. Likewise, although some restrictions on physician-controlled hospitals are desirable to prevent their "cherry picking" patients, current law unnecessarily impedes their development. In addition, allowing middle-level professionals, such as nurse practitioners and physician assistants to practice within the

[23] LEAVITT PARTNERS, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: AUGUST 2013 UPDATE (2013), *available at* http://leavittpartners.com/wp-content/uploads/2013/08/Growth-and-Disperson-of-ACOs-August-20131.pdf.

[24] Several organizations have begun looking at ways to address the provider monopoly problem. *See e.g.*, CATALYST FOR PAYMENT REFORM, PROVIDER MARKET POWER IN THE U.S. HEALTH CARE INDUSTRY: ASSESSING ITS IMPACT AND LOOKING AHEAD (2012), *available at* http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf.

full scope of their professional license under state law may increase the number and viability of new organizational arrangements such as medical homes and accountable care organizations that may be able to exert pressure on dominant providers.[25] Because Medicare payment policies strongly influence the methodologies adopted by private payors, encouraging and accelerating the myriad efforts at reimbursement reform currently underway would help insure that dominant providers adopt quality-improving, cost-effective practices. Finally, as a general matter federal and state legislatures should stoutly resist pleas for immunity or special protections from competition laws; there is a strong consensus, based on the nation's experience, that such exemptions harm consumer welfare.[26]

A second means of dealing with provider concentration is to use the full measure of authority under the antitrust laws to challenge the *abuse* of market power by dominant hospitals, physician groups and pharmaceutical companies. Among the important issues on the antitrust agenda are resisting claims of "State Action" where the state legislation does not follow the Supreme Court's requirement that the defense is available only where state law truly endorses anticompetitive conduct and the state actively supervises the effects on consumers. Other steps might include retrospective challenges to recent mergers where divestiture is feasible. Further, following some path-breaking scholarship by Professors Havighurst and Richman, antitrust law may be deployed to charge dominant hospitals with illegal tying or bundling, so as to force them to compete on the services that they do not monopolize.[27]

Finally, it may be possible to strengthen private market participants' ability to negotiate with dominant providers through governmental actions. For example, commercial insurers are currently engaged in testing a variety of devices, such as using tiered networks, reference pricing, and value pricing to incentivize patients to choose more cost-effective providers, equipment, and service options. However, dominant providers have insisted on contractual terms (e.g., so-called "anti-tiering" clauses) to block such arrangements. Although antitrust law might in some instances prohibit such agreements, more direct, regulatory prohibitions would provide much-needed protections more efficiently. And as discussed earlier, states might follow Michigan's example in outlawing most favored nations agreements that have been shown to reduce price competition in both the hospital and insurance sectors. The expertise and leverage of agencies regulating insurers might also be called upon. For example, state

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[25] The FTC staff has addressed the issue of expanding the opportunity of complementary providers to compete in several letters to state legislatures. *See e.g.*, Letter from FTC Staff, to the Hon. Theresa W. Conroy, Conn. State Rep. (March 19, 2013) (on file with author) (supporting proposed legislation to remove certain restrictions on advanced practice registered nurses' ability to practice within their scope of practice), *available at* http://www.ftc.gov/os/2013/03/130319aprnconroy.pdf.

[26] As the nonpartisan Antitrust Modernization Commission has explained, antitrust exemptions "should be recognized as a decision to sacrifice competition and consumer welfare" that benefits small, concentrated interest groups while imposing costs broadly upon consumers at large. ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 350 (2007), *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[27] Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 Or. L. Rev. 847 (2011).

health insurance exchanges or state regulators might require unbundling of hospital services, as suggested by Professors Havighurst and Richman. For its part, CMS should carefully review the performance of ACOs, and where appropriate, decline renewal of contracts if market power has been exercised over private payers. Likewise, regulations and payment policies that favor ACOs controlled by primary care providers rather than dominant hospitals could serve to reduce the impact of the latter's market power.

It should be remembered that the foregoing options are designed to address the provider monopoly problem while preserving the market paradigm on which health care reform currently rests. A last resort, should other options fail, would be to invoke regulatory authority to curb excessive pricing, such as requiring all payer rate controls or empowering insurance commissioners to place caps on excessively expensive provider contracts.

Conclusion

A core concern of the Affordable Care Act is promoting competition in health care. Responses to the law such as anticompetitive mergers and cartel activity should be understood as efforts to avoid the discipline the new market realities will impose. Vigorous enforcement of the antitrust laws is essential to dealing with those problems, but at the same time the law is of limited help in dealing with extant market power. Legislators and regulators should be alert to opportunities to improve the prospects for entry and increased competitive opportunities where monopoly power is present.

Mr. BACHUS. Thank you.
Mr. Balto?

TESTIMONY OF DAVID BALTO,
LAW OFFICES OF DAVID BALTO

Mr. BALTO. Thank you, Chairman Bachus and the other Members of the Committee. I am David Balto. I am the former Policy Director of the Federal Trade Commission. I am a public interest antitrust attorney.

I have a simple message. Does the Affordable Care Act matter to consumers? You bet it does. In 2 weeks, health insurance exchanges will be formed. Very few people would contest the competitive problems in the health insurance market. Those exchanges will offer consumers the ability to do one-stop shopping and will lead to greater competition between health insurance in markets in which there is barely enough competition as it is.

Does the act matter? The act provides that when health insurers companies increase rates too much, the Secretary of HHS can just say no. And she did last year, and she forced them to return over $1.2 billion to over 6.8 million consumers. That is over $1.2 billion in excessive rate increases by insurance companies.

Now, my testimony is like the other people's testimony, focusing on the problems in the health care market. Five key points.

First, there is increased consolidation, but as other people have said, there are lots of reason for that consolidation, not just the Affordable Care Act. It existed before the Affordable Care Act passed.

Second, there is a tension between the Affordable Care Act and some of the past antitrust enforcement. To be honest, as a past antitrust enforcer, antitrust enforcers like atomistic health care providers. They prefer to see lots and lots of competition. But recent scholarship has really shown us how an atomistic health care market, especially on the provider side, leads to increased health care costs. That is why the Affordable Care Act incents greater integration, and that integration is positive.

Third, antitrust enforcement is going in the right direction. I applaud my co-panelist, Sharis Pozen, who as the Deputy Assistant Attorney General of the Antitrust Division helped revitalize health insurance antitrust enforcement, stopping anticompetitive mergers where there had been barely any enforcement before.

Fourth, is antitrust enforcement enough? No, it is not. Antitrust provides a limited tool. What we really need to look for, as Congress did in the Affordable Care Act, are increased means of regulation. What should enforcers do? Well, what they should not do is approve otherwise anticompetitive mergers because they think they will fulfill the mission of the Affordable Care Act. That is what the FTC did when it approved the merger of Express Scripts and Medco, two of the three largest PBMs. That is making a deal with the devil. They thought that would lead to greater bargaining power that would hold down drug costs, but what it is leading to today is consumers having less choice and having to pay more and community pharmacies suffering a great deal.

Now, let me just touch on two small issues here.

First, rural antitrust. Whenever antitrust cops look at a rural market, they see somebody with a big market share and they think

it is time to take out their antitrust guns. That is a mistake. The antitrust authorities have to recognize the unique characteristics of rural markets and the need for rural hospitals and doctors to be able to effectively collaborate. And when the antitrust standard is set up too high, when they prevent those folks from being able to collaborate, those hospitals in those small towns have no choice—they have no choice—but to sell out to the big hospital system in the major metropolitan area.

Second, the advocacy by antitrust enforcement agencies. The antitrust enforcement agencies, rather than trying to welcome State regulation, oftentimes oppose State regulation. I provide two examples where the antitrust folks said, no, consumer choice would not work here. I mean, Professor Greaney just talked about transparency. I can show you four letters where the FTC opposes transparency when it comes to pharmacy benefit managers. Fortunately, oftentimes, including in your States, the State legislatures pay the FTC no heed. But if the FTC is not going to take more aggressive enforcement actions here, the least they should do is not try to stop States from being able to effectively regulate.

I have five suggestions at the end.

First, the FTC and DOJ need to focus on payers. That is insurance companies, PBM's, and also group purchasing organizations. That is where there are chronic competitive problems. These markets are overly concentrated.

Second, the FTC, in looking at these markets, should use its power under section 5 of the FTC Act to go after unfair trade practices and unfair methods of competition that are not technical violations of the antitrust law.

Third, everybody applauds the FTC's retrospective study of hospital mergers. We should do the same for health insurance. There was just a study issued earlier this year that looked at the United-Sierra merger in Nevada that found that consumers are paying 13 percent more in premiums because the Justice Department approved that merger. We need more of those studies to figure out where we need to have greater health insurance antitrust enforcement.

Fourth, the enforcement agencies need to recognize it is not the PBM who is the consumer. It is not the insurance company that is the consumer. It is you and me are the consumer. Too often, like in the Express Scripts-Medco merger, the FTC approves things thinking that the PBM is really the consumer and not looking at the ultimate consumer.

Finally, we have a problem which is in 2 weeks the insurance exchanges go live, and we do not have a national consumer protection cop on health insurance. The FTC says the McCarran-Ferguson Act prevents them from being a health insurance cop. I think they are wrong. But to the extent they might not be wrong and McCarran-Ferguson prevents them from protecting consumers from egregious practices by health insurance companies, it is time to repeal the McCarran-Ferguson Act, as suggested by Congressman Conyers.

Thank you for the opportunity testify, and I welcome your questions.

[The prepared statement of Mr. Balto follows:]

Statement of David Balto

Before House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Hearing on

"The Patient Protection and Affordable Care Act, Consolidation and the Consequent Impact on Competition in Healthcare"

September 19, 2013

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Statement of David Balto[1]

Before House Judiciary Committee Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Hearing on "The Patient Protection and Affordable Care Act, Consolidation and the Consequent Impact on Competition in Healthcare"

September 19, 2013

Chairman Bachus, Vice-Chairman Farenthold and Ranking Member Cohen and other members of the committee, I appreciate the opportunity to come before you today and testify about healthcare industry consolidation. As a former antitrust enforcement official and someone who represents everyday consumers and healthcare providers I know that 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. A recent survey I authored for the Robert Woods Johnson Foundation documented the economic evidence of increased consolidation and its effects in all healthcare markets.[2]

Today's hearing seems to pose the question of whether the Affordable Care Act (ACA) leads to greater consolidation and potential competitive problems.

- Although there is increased consolidation among healthcare providers that is due to a wide variety of factors including the need to achieve greater efficiencies, respond to the increasing demands for integrated care, achieve greater quality of healthcare, and deal with excess capacity and weakened financial status. The trend of increased hospital consolidation in particular existed even before the enactment of the ACA and the ACA did not significantly increase the demand for consolidation.
- There clearly is a tension between the goals of the ACA and the traditional approach to healthcare antitrust enforcement. The ACA recognizes the extreme costs of fee for service healthcare and the unintended costs of a lack of integration in healthcare delivery (known as the "silo effect"). The ACA also recognizes the lack of competition in health insurance markets. The ACA attempts to deal with both of these issues by (1) encouraging collaboration and integration through the creation of Accountable Care Organizations (ACOs) and (2) attempting to spur health insurance competition through the creation of health insurance exchanges, the creation of health insurance cooperatives, and the establishment of rules to assure most of health insurance expenditures result in the delivery of healthcare.

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[1] I am former policy director of the Federal Trade Commission and was actively involved in several healthcare enforcement matters and revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care. I represent consumer and patient groups, pharmacies, healthcare providers and insurers on various competition issues. This testimony represents solely my views.

[2] David Balto and James Kovacs, Consolidation in Healthcare Markets: A Review of the Literature (January 2013), available at, http://dcantitrustlaw.com/assets/content/documents/2013/balto-kovacs_healthcareconsolidation_jan13.pdf.

- On the other hand traditional antitrust enforcement appears to be at odds with some of these efforts. Some past antitrust enforcement has treated integration with unnecessary skepticism. Some of this skepticism should be appropriate when there is a significant threat of the exercise of market power. But in many cases in the past decade the FTC has imposed unwarranted burdens on collaborations that could improve integration and the delivery of healthcare.
- Fortunately, the current enforcers have strengthened the efforts at restoring competition through focused enforcement actions against provider and insurance consolidation. The agencies should continue to prevent problematic consolidation and aggressively pursue anticompetitive conduct by dominant firms. But antitrust enforcement is an extraordinarily limited tool. It typically cannot unravel market power that has been lawfully acquired.
- But often regulation is necessary to respond to markets that do not function effectively. The antitrust enforcers must work more proactively to assist state and federal enforcers in developing efforts to regulate payor and provider market power. Unfortunately, the agencies have expressed an unhealthy skepticism to state healthcare regulation in the past and that approach should change.
- Finally, the ACA and the need to control healthcare costs should not be the basis for approving an otherwise problematic merger among healthcare payors. Parties may argue that the ACA forces them to merge in order to gain bargaining leverage. These arguments should be treated skeptically. This could have been part of the reason the FTC mistakenly approved the merger of two of the three largest pharmacy benefit managers – ESI and Medco.

A single example of the profound impact the Affordable Care Act is having on controlling healthcare costs is the rate review provisions. Last week HHS announced the rate review provisions of the ACA saved an estimated $1.2 billion on health insurance premiums in 2012 for 6.8 million policyholders.[3] While increased transparency to hold health insurers accountable for increasing premiums is most welcomed, as described below, the importance for coordination between legislators and antitrust agencies to address competitive problems in healthcare markets cannot be overstated.

My testimony today highlights how the combination of the ACA and renewed antitrust enforcement are grappling with competitive problems in healthcare markets. It focuses on health insurance concentration and then turns to concentration among healthcare providers. It addresses how the Affordable Care Act and state regulation offer the potential to significantly spur healthcare competition and closes with several recommendations to strengthen healthcare antitrust enforcement.

Adapting the Antitrust Paradigm: Focusing on Health Insurance Consolidation

The first priority of antitrust enforcers should be to prevent further consolidation of health insurance markets. Lax enforcement has led to a very poorly functioning health insurance market. Few markets are as concentrated, opaque, and as conducive to deceptive and

[3] US Dept. of Health and Humana Services: Rate Review Annual Report (September 2013), available at http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm.

anticompetitive conduct. Congress has recognized time and again that these markets lack sufficient competition and transparency, so I will highlight why the lack of competition and effective transparency in health insurance markets is so problematic.

There are three necessary components of a functioning market: choice, transparency, and a lack of conflicts of interest.[4] 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 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 2012 AMA study found over 90 percent of 385 metropolitan areas, representing all 50 states and the District of Columbia were "highly concentrated." In 89 percent of markets, one insurer had a commercial share of 30 percent or greater. 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.

When it enacted the ACA Congress heard from scores of consumers about the harms from this dysfunctional market. The number of uninsured patients has skyrocketed: more than 48 million Americans are uninsured, and according to The Commonwealth Fund, as many as 84 million Americans, nearly half of all working-age adults went without health insurance for a time last year or had such high out-of-pocket expenses relative to their income that they were considered under-insured. Since 2003, premiums have increased 80 percent, nearly three times as fast as the average wages and inflation. 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, with private insurance revenue increasing even faster than medical costs.

Empirical economic studies have also documented the harm from health insurance mergers. A recent study documented how consolidation in various Texas markets led to higher premiums of about 7 percent.[5] The study also found that the increase in concentration led to lower premiums paid to healthcare providers, and contributed to the substitution of nurses for doctors in many markets. Consumers suffer not only from higher premiums but reductions in service.

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[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] David Balto and James Kovacs, Consolidation in Healthcare Markets: A Review of the Literature (January 2013), available at, http://dcantitrustlaw.com/assets/content/documents/2013/balto-kovacs_healthcareconsolidation_jan13.pdf.

A more recent study addresses the impact of the merger of UnitedHealth Group and Sierra Health Services, two of the three largest insurers in Nevada that was approved by the DOJ in 2008. The study found that the merger led to the exercise of market power – premiums for small businesses increased by over 13 percent after the merger compared to a control group.[6]

Revitalized Health Insurance Antitrust Enforcement

The prior administration failed to challenge any mergers or anticompetitive conduct by health insurers during the entirety of its tenure,[7] 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 challenged Blue Cross Blue Shield of Michigan's proposed acquisition of Physicians Health Plan of Mid-Michigan. The Department determined that this acquisition would result in BCBS controlling nearly 90 percent 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."[8] As a result of this concentration and likely anticompetitive results, the DOJ announced its intention to enjoin the merger and the deal was abandoned. This was the first time the DOJ threatened to go to court to block a merger and their willingness to litigate made a difference.

The DOJ continues to carefully evaluate insurance mergers. In November 2011, the DOJ required the divestiture of New West Health Services' commercial health insurance business when it attempted to enter an agreement with Blue Cross Blue Shield Montana for the provision of health insurance services for 5 of the 6 hospital owners of New West. Additionally, in March 2012, the DOJ required a divestiture to protect competition in Medicare Advantage contracting.[9] The proposed merger between Humana and Arcadian Management Services threatened to substantially decrease competition in 45 counties across five states, and the combined company

[6] Guardalo, Emmons and Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" Health Management, Policy and Innovation 1 (3) 16-35 (2013).
[7] 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.
[8] 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
[9] United States v. Humana Inc. and Arcadian Management Services, No. 12-cv-464 (D.D.C. March 28, 2012).

would have controlled 100 percent of the Medicare Advantage market in at least five geographic regions.

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.[10] 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 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.

These agreements raised prices for commercial health insurance; restricted competition among health insurer providers; restricted choice by Michigan hospitals; and, ultimately led to less hospital services available. Blue Cross lost on its motion to dismiss the case as the court concluded that the government sufficiently alleged plausible markets, anticompetitive effects, and a legal theory of harm.

In March 2013 the Michigan legislature, recognizing the harmful effects on consumers and competition in the healthcare marketplace, passed laws prohibiting the use of MFNs by insurers, health maintenance organizations, and nonprofit healthcare corporations in contracts with providers. As a result the DOJ dismissed its case.

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, 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. 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. I have testified before this Committee that these were misplaced enforcement priorities, since there was little

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

evidence this conduct harmed competition.[11] 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. The FTC and states have appropriately challenged some potentially harmful mergers. 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.

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 FTC's challenge to the merger of ProMedica and St. Luke's Hospital, the first and third largest hospitals in Toledo, Ohio.[12] 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. Ultimately, the FTC secured a preliminary injunction against the merger in U.S. District Court in Ohio, and last year the FTC ordered ProMedica to divest St. Luke's Hospital. ProMedica filed an appeal of the Commission's decision to the US District Court of Appeals for the Sixth Circuit, which is currently pending.

More recently, the FTC secured an injunction blocking the proposed merger between OFS Healthcare System and Rockford Health System. The FTC alleged that the combination of the dominant health systems would result in significant concentration the market for general acute care services in Rockford, Illinois. This combination would have given the merged entity greater leverage to increase costs and decrease quality, convenience and the breadth of services provided to local residents.[13] The court enjoined the merger and OSF abandoned the transaction.

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[11] 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).

[12] *In the Matter of* ProMedica Health System, Inc., FTC Docket No. 9346 (March 28, 2012) available at www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf.

[13] *In the Matter of* OSF Healthcare System and Rockford Health System, FTC Docket No. 9349 (Nov. 17, 2011) available at www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf.

One of the most challenging areas is where a significant hospital acquires a significant physician practice. Since the hospital and physicians are not direct competitors the acquisition is vertical and it traditionally is more difficult to challenge vertical mergers. Most recently, the FTC sued St. Luke's Health System to enjoin its acquisition of Idaho's largest independent, multi-specialty physician practice group, Saltzer Medical Group. The acquisition would give it the market power to demand higher rates for healthcare services provided by primary care physicians in Nampa, Idaho and surrounding areas, ultimately leading to higher costs for healthcare consumers.[14]

Last year, the FTC sued Renown Health a large hospital system for its acquisition of two competing cardiology practices. The acquisition would have allowed Renown to employ 88 percent of the cardiologists in the Reno area. Renown resolved the competitive concerns by agreeing to release ten cardiologists from the non-compete covenant Renown required each physician to sign.

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, and that effort has continued since the enactment of the ACA. 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 percent market share in the market for inpatient hospital services, and 65 percent 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.[15]

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 percent if they contracted 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

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[14] *FTC v. St. Luke's Health System, et al.*, No. 12-cv-560 (D. Idaho).
[15] *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 have discussed in past testimony, that paradigm was deeply skeptical of integration by healthcare providers, particularly of efforts by physicians to collaborate. The debate over the enactment of the ACA 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. As I mentioned in my introduction the ACA has already had a significant impact on health insurance costs – effectively reducing premiums by over $1.2 billion in 2012.

Let me highlight a few other tools. First, in 2014, 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, 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 among 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 ACA, physicians, hospitals, and other healthcare providers are encouraged to reduce cost by, among other things forming ACOs. Hundreds of ACOs have been formed. While ACOs involve collaboration among competitors, which has frequently raised antitrust concerns, skepticism of integration provider groups can be 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 standards adopted by the agencies for ACOs provide progress in this area. Antitrust standards should enhance the opportunities for physician-sponsored ACOs that would provide 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 have demonstrated the importance of antitrust enforcement in preventing the creation or the improper preservation of market power.

The agencies clearly need to focus greater attention in those situations where specialized physician groups 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.[16] 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.

The Need for Increased Regulation

Antitrust enforcement is an important solution but a limited one. The DOJ and the FTC have limited resources. 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 firms in an already concentrated industry from acting anticompetitively through enforcement of the Sherman Act or the FTC Act. 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. Regulation may be the most effective approach to problems antitrust cannot address. There are several examples worth considering.

One of the most effective forms of regulation has been state regulation of rate setting. When in use by states, there is significant empirical evidence that rate setting helped slow aggregate total hospital spending in states such as New Jersey, New York, and Washington.[17] While many states have since abandoned a more forceful regulatory approach, some states are

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[16] *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).

[17] Sommers, White, & Ginsburg, "Addressing Hospital Pricing Leverage through Regulation: State Rate Setting," 9 POLICY ANALYSIS 1, 2 (2012).

continuing to maintain or beginning to create a sufficient regulatory scheme that will enable healthcare efficiencies, while also controlling costs.

The model state continues to be Maryland. Through the Health Services Cost Review Commission ("HSCRC"), the state has continually "bucked" the trend of substantial increases in hospital rates. In fact, according to the 2012 report, the difference between hospital costs and charges actually paid in Maryland stands at a national low of only 27 percent compared to a national average of 212 percent markup for services.[18] Furthermore, while many people have argued that the HSCRC and their price controls and macro-style regulation would lead to a lower standard of care, Maryland's healthcare continues to thrive. Maryland continues to pace the nation as one of the top states for both quality and access to care.[19]

In Massachusetts, the state whose healthcare system represented the model for the ACA, began an aggressive regulatory approach to combat higher healthcare prices, through the passage of the Health Cost Containment Bill. Enacted in August of 2012, the law is projected to save Massachusetts nearly $200 billion dollars over fifteen years. The state will achieve these savings through setting healthcare cost benchmarks, reforming Medicaid, establishing ACOs, medical malpractice reform, and other initiatives including expanding consumer protections and patient access.[20]

Given their expertise and understanding, states are better situated to deal with local market power and exclusionary conduct in insurance and provider markets. The success of states thus far demonstrates their capability to regulate local healthcare markets. The federal agencies should find constructive ways to advise states on their efforts to regulate.

Unfortunately the antitrust enforcement agencies typically see regulation as an anathema and often oppose state efforts at healthcare regulation. In particular, when states have attempted to deal with anticompetitive practices or the market power of insurers or pharmacy benefit managers (PBM) the FTC has traditionally opposed these efforts. For example, the FTC opposed the enactment of a statute to facilitate the development of rural health cooperatives in 2009.[21] And it opposed the enactment of legislation to prevent mandatory drug mail order programs in New York in 2011.[22] In both case the state legislatures rejected the FTC staff advice and enacted the legislation. From the prospective of these legislatures the real consumer is the patient and not the for profit financial intermediary.[23]

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[18] The Maryland Health Services Cost Review Commission, "Report to the Governor Fiscal Year 2012," available at http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/AnnualReports/GovernorsReport2012-MD-HSCRC.pdf.

[19] Agency for Healthcare Research and Quality, "2012 National Healthcare Quality Report," available at http://www.ahrq.gov/research/findings/nhqrdr/nhqr12/2012nhqr.pdf.

[20] *See* Health Care Payment Reform Conference Committee Report (2012), available at http://www.mass.gov/governor/agenda/healthcare/cost-containment/summary-health-care-payment-reform-conference-committee-report.pdf.

[21] *See* letter from Federal Trade Commission to Rep. Tom Emmer (March 2009), available at http://www.ftc.gov/opp/advocacy/V090003.pdf.

[22] *See* letter from the Federal Trade Commission to Hon. James L. Seward (August 8, 2011), available at http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf.

[23] I represented some of the proponents of both of these laws. *See* David Balto, FTC v. Lake Wobegon, Hospitals and Health Networks (April 1, 2011), available at

The Special Problems of Rural Markets

Antitrust enforcement must be sensitive to the unique aspects of every market. In healthcare there are numerous underserved markets, especially in rural areas. Rural healthcare creates unique problems because rural areas are sparsely populated, often low income, and have a higher portion of consumers on public assistance. In addition, it is difficult to attract doctors and keep hospitals operating in rural markets. That is why there are numerous government programs to support rural healthcare, such as critical access hospital programs.

Unfortunately, the antitrust enforcers have not always recognized the complex challenges of rural markets. Rural markets typically have very few competitors so the typical antitrust rules of thumb would probably find almost any kind of merger or collaboration illegal. For example, in the early 1990s the FTC challenged a merger of two small hospitals in Ukiah California a community of less than 20,000. (This challenge led to a Congressional inquiry). In 2009, the FTC opposed an effort by the Minnesota legislature to facilitate the development of rural health cooperatives, a provision that was enacted into law. The agencies have recognized concerns, however, in their guidance on ACOs and rural hospital mergers.

The FTC is currently challenging an acquisition of a multi-specialty physician group in Nampa, Idaho a town of about 80,000 by St. Luke's Health System a major health system in Boise. The FTC alleges that the acquisition will enable St. Luke's to increase prices to health plans and employers. In addition, the FTC alleges the acquisition will reduce the potential the formation of alternative networks.

Like any vertical acquisition (a merger not involving direct competitors) there are potential efficiencies from this type of arrangement, including better integration between hospital and physicians. These efficiencies may be particularly important in rural areas such as Nampa and may lead to provision of higher quality services. These are challenging issues and the FTC challenge is about to go to trial.

There can be sound reasons to believe this type of acquisition will improve patient care and help fulfill some of the goals of the ACA. This type of integrated model has succeeded in other markets, helping to lower costs. Secondly, this type of acquisition can facilitate a shift in the market from a "fee-for-service" model to a value based metric for compensation. These issues deserve serious consideration in this case and similar acquisitions.

Recommendations

Ultimately, concerns with healthcare 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

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http://www.hhnmag.com/hhnmag/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/04APR2011/0411HHN_Outbox&domain=HHNMAG; *see also* letter from David Balto to Hon. Andrew Cuomo regarding support for assembly bill 5502-B to eliminate mandatory mail order pharmacy services (October 17, 2011), available at http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ny-ammo-letter-cuomo.pdf.

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 administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious, and deceptive conduct by insurers, and other intermediaries such as PBMs.** 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.
4. **Conduct a retrospective study of health insurer mergers.** The FTC or the DOJ should 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 hospital 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. **Recognize 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.[24]

[24] 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).

Mr. BACHUS. Thank you, and I think it is very thorough testimony by all the panelists. I very much appreciate it. That is a tremendous amount of information to try to absorb and analyze.

At this time, I will recognize the gentleman from Pennsylvania, Tom Marino, for questions.

Mr. MARINO. Thank you, Chairman.

Good afternoon, panel. Thank you for being here.

I am going to try and stay focused on the antitrust aspect of this, even though I do oppose most of what Obamacare has to offer, which I think is very little at this point.

But, Mr. Balto, you talked about rural hospitals. I come from Pennsylvania, the 10th congressional district, very rural, largest geographic district in the State of Pennsylvania. I visited all of my hospitals since I have been in Congress, being elected and taking office in 2011, numerous times. And one of the biggest complaints that I hear from the administrators is the cost of administration and not being able to provide the services because they are in a rural area with escalating costs.

Are you saying that—and I think you touched a little bit on the fact that rural hospitals are a different type of animal. Am I correct in that? Please go ahead.

Mr. BALTO. Yes. First of all, many rural hospitals are critical access care hospitals.

Mr. MARINO. Yes.

Mr. BALTO. We are trying to preserve them. Because of the limited population, it is hard for them to attract doctors, and they have a very high cost structure.

Mr. MARINO. So are we talking about two sets of rules then pertaining to Obamacare and rural hospitals versus metropolitan hospitals?

Mr. BALTO. So the agencies had to come up with the antitrust standards for affordable care organizations. They came up with a special provision for rural ACOs to try to provide them a little more leeway to form ACOS, recognizing that any ACO would probably appear to have market power. I do not think that went far enough, and I do not think we see enough development so far of rural ACOs.

Mr. MARINO. Professor Greaney, you talked about—I wish I had an hour to discuss this with each of you. I took so many notes during your input.

You talked about more regulation. Did I understand that properly? You think we need more regulation by the Federal Government when it comes to health care.

Mr. GREANEY. I am talking about State and Federal regulation that would really do away with pre-existing legislation and other regulations that block entry, such as certificate of need and so forth. But at the same time, for those markets in which there are dominant provider markets, there really is not a good competitive solution to ensure price competition simply because there is not any price competition.

Mr. MARINO. But how do you do that in a situation concerning hospitals? It is very complex. They have to cover a multitude of needs that walk through the door. They certainly have to have—it is a great deal of paperwork involved as it is now. That appears

to me—and I am told by the administrators that their paperwork is increasing. Their costs are going up. And then factor in the aspect of what hospitals are not paid because when people come in, at least in Pennsylvania and I am sure across the country, you provide care for people who are injured even though they cannot pay for it. So how does all that factor into when you were saying we need more competition? Because does it not make companies run more lean?

Mr. GREANEY. Well, first of all, let me mention that much of what the Affordable Care Act tries to do is remove those burdens of uncompensated care that they are providing through Medicaid expansion and other means.

Mr. MARINO. I understand that. I mean, that opens up a whole other can of worms as to who is going to pay for this. But aside from that—and I will let you finish here in a minute. I just want to throw out this other thought. Are you saying that regardless if it is a government entity controlling a hospital or it is a private hospital, that overlapping services, if they are eliminated, are not going to lower the cost of health care?

Mr. GREANEY. I think the issue that we are addressing today is dominant hospitals that have achieved market power such that they can charge monopoly prices. And the question is whether antitrust can do anything about that. And I am afraid the answer is very little or nothing.

So the question for regulators such as insurance commissioners or certain States might be to put some kind of benchmark or caps on provider pricing. That is a regulatory option, but frankly that is one of the few tools they have.

On the other hand, other measures such as ACO's and patient-centered medical homes, might provide some pressure from the ground up to reduce over-prescribing and excess costs.

Mr. MARINO. I see my time has expired. I will close with saying this. I get constant calls in my office from businesses, large and small, and from individuals as to say what do I do about my health care now. And we go a step further. We try to touch base with HHS and ask the questions, not pertaining to antitrust, but just services, and we get no answers. The answer we get is we do not know at this point. So that is one of my biggest problems with Obamacare.

It is very clear that businesses are now saying to their employees we are going to have to take your family off the health care program or you are going to have to pay more into it or we may eliminate it. Whereas I admit antitrust is a big factor, it is a project of mine watching antitrust issues concerning particularly the pharmaceuticals, as you discussed—and you and I know about that a little bit. But there are many other issues concerning this.

I yield back and thank you, gentlemen.

Mr. BACHUS. Thank you.

Mr. Smith? No questions? Okay. Thank you.

Let me ask you this. Professor Richman, you and Professor Greaney have said you agree on certain things that could be done to increase competition. Have the other panelists—are they aware of what they have proposed? Is there any awareness of some of the things they have proposed? Maybe you ought to comment on some of the things they have proposed.

Mr. JOSEPH MILLER. Thanks for the question.

I would like to start with the idea that everybody here seems to agree on that antitrust does not have a big role to play once a provider has aggregated market power. Historically that has been true. The FTC has tried it in the Evanston case. That case was something like 7 years from the beginning of the investigation until the litigation ended in a settlement. So it is not a solution that is going to get to the whole problem, but I do not want to let the moment pass without saying antitrust laws still have jurisdiction and if there is the right case, the agencies can go back and look at a consummated merger.

In terms of the other proposals, we have not taken a position. I think they are all worthy of further study and debate. There are some that are relatively obvious to be in favor of, allowing practitioners to practice to the top of their licenses, lowering regulatory barriers to entry for competitors, and those sorts of things. There is a lot that has been suggested that is worth discussing.

Mr. BACHUS. Mr. Miller or Mr. Balto or Ms. Pozen?

Mr. THOMAS MILLER. Sure. Full disclosure, since I edited and published a study by Professor Richman, I would agree with many of his prescribed remedies.

Let me just say as a preliminary, though, you know, there is a tendency when you talk to folks in antitrust—it is the old hammer and nail situation. They have a certain set of tools they can normally apply, and therefore, they find problems to which they can apply their remedy. In the area of hospital mergers, one of the reasons why the problem is not large anymore is hospitals have run out of targets. They are about as consolidated as they can be, and there are not many more opportunities to consolidate although there have been some rollbacks recently.

We need to focus a little bit more on a different type of regulatory barrier to entry, which is the simple cost and burden of complying with regulation keeps the new entrants out of the field. You know, we think we are doing so many wonderful things with regulation, but we might be closing out and foreclosing the opportunity for someone to enter that business in a less conventional mean. It is not just scale. It is the ability to have the lawyers and compliance experts to get in the door. Health insurance is a hard area to get into to begin with. It is hard to start up new hospitals. We raised the bar even higher by the thickening web of what it takes to actually be a going concern in that regard.

On the remedies, I think they are all worth exploring to the extent that they improve market entry and also facilitate market exit.

I think the unbundling issue is a little harder to parse. I think it is promising. We have not figured out exactly where the thresholds are for where it could be applied. There was a lot of bad antitrust law in the past which over-exaggerated the degree to which you can leverage market power from one area to another. That may, though, be applicable in the case in which Professor Richman is talking about. We would have to go in and have to probe that a little bit further as to what is a workable way to actually carry that out.

Again, we keep forgetting that transparency can go a long way. The folks in Massachusetts who talked so much about the terrible consolidation and all the anticompetitive practices, when they finally got to the end of the line, they had to say, you know, it is not just a matter of more exotic payment and integration. We have to be able to find a way to measure this stuff and make it transparent to the people who are actually paying for it, and that is where you will get the real push-back from the true consumers and purchasers in this area.

Mr. BACHUS. Ms. Pozen and then Mr. Balto.

Ms. POZEN. If I could, I just wanted to refocus a bit on this issue of consolidation in hospitals. As I mentioned in my testimony and it is further elaborated on in the written testimony—and we actually can provide a study from 2007 to 2013 in terms of the number of hospital mergers. We actually calculated the number in the United States and found that number to be at 12 percent of the total number of hospitals. So this notion of consolidation and undue consolidation through mergers and acquisition—I think the study that the AHA commissioned from the Center on Healthcare Economics and Policy really rebuts that notion.

I think, secondly, there has been a lot of discussion about retrospectives, and I really commend the Committee to think long and hard before it would advocate retrospectives in the hospital industry. Those were done previously. I think those who participated in that, the hospitals and the millions and millions of dollars that they had to pay to be reviewed by the antitrust agencies many years, as Mr. Miller mentioned after the mergers had occurred, would dispute the effectiveness of those retrospectives. Those that were actually involved in it like my former mentor and Commissioner Tom Leary who was at the commission at the time, wrote afterwards that he did not think those should ever be undertaken again, that they were not worthwhile.

And I would add, as I mentioned in my testimony, you have the hospital industry going through tremendous change, these models of delivery, as I mentioned, and the drive toward efficiency and value. To undertake a retrospective and divert a hospital from its mission to serve patients to respond to a Government inquiry I think one should think twice before advocating that.

Mr. BACHUS. Mr. Balto?

Mr. BALTO. Thank you.

You know, I just want to make an observation. From time to time I represent small town hospitals. I also sue hospitals actually for antitrust violations. We have all mentioned price. None of us have mentioned service. And I think that everybody has to be cautious about the extent that perhaps increases in reimbursement rates lead to improved service and how that goes into the balance.

Now, as to the question of remedies, remember what Professor Richman is talking about is improving life for the insurance companies. The insurance companies will be able to—will not be paying as much to hospitals. Does that matter to the consumer? It depends if the insurance market is competitive and it results in lower premiums. But right now insurance markets are not particularly competitive. To the extent, as Professor Richman observes, that insur-

ance exacerbates the problems of provider market power, I think having monopoly insurance makes those problems much worse.

As to the two suggestions Professor Richman has, look, there is a more efficient answer than antitrust enforcement. The DOJ brought a big case to challenge a single most favored nations provision, and that is it. The case ended when the State passes legislation. Could it have been better for the DOJ to issue a guideline saying most favored nations provisions are illegal? Would it have been better instead of going to court for the DOJ to go to State legislatures and try to get them to pass similar legislation? Sometimes there are more effective ways than antitrust enforcement.

As to Professor Richman's approach on bundling arrangements, I think that is certainly worth exploring. By the way, those bundling arrangements are clearly a problem when we look at the pharmaceutical industry where pharmacy benefit managers effectively force consumers to buy specialty drugs, very expensive drugs for people with chronic conditions, from the PBM's own specialty pharmacy. Every one of the problems that Professor Richman has identified there is in spades when you look at pharmacy benefit managers.

Mr. GREANEY. I want to drill in one more point about regulations. I alluded to the fact that there are important changes underway right now with respect to Medicare payment both the physicians and hospitals. And I think it is important for Congress to support some of the recommendations coming out of CMS and, most importantly, out of Medpac.

One great example is the fact that some of the physician acquisition by hospitals is motivated by the fact that the hospitals can charge a higher fee for the very same services that were provided independently in the doctor's office, and that certainly is an incentive, a very perverse incentive, for acquisition.

So I think Congress should pay attention to what Medpac and others are saying, and I think the reforms that are underway, partially spurred by the Affordable Care Act, are very important. They are looking at retooling how we pay doctors because we have a fairly absurd system.

And by the way, Medicare payment policy is followed by private payers in many, many instances. So the fact that we pay physicians based on inputs of their costs rather than outcomes and their value is a complete distortion, and the fact that private payers follow that model is important. So Medicare reform is very important in driving both efficiency and competition in the private market.

Mr. RICHMAN. If I could just add two small points. Actually both of them relate to what my fellow panelists have already said.

Professor Greaney points to one feature which is really endemic throughout the industry, which is how providers and insurers alike seek to exploit different loopholes in the reimbursement system. And to a large degree, this is the market model that most providers have assembled. And I think it, to one degree, was why Congressman Marino has observed in his district and districts throughout America—why the administrative costs of running hospitals are so high. It is because they respond to these different incentives both with public payers and private payers. The whole market model is

one designed to capture a market and extract maximum dollars from payers.

There is an alternative business model, which really has not been pursued a whole lot among providers, and that is to really pursue efficiency or value-based models. It is one reason why business education is so critical to encourage both providers and administrators to really pursue. It really involves a very different kind of economic model.

That also speaks to one very interesting dynamic that we heard both from Ms. Pozen and Mr. Joe Miller. Mr. Chairman, you observed in the beginning you were hoping to hear from all sides, and what is funny about that conversation you hear out of AHA and AHIP is sometimes you are hearing both sides of what really is the same coin. The insurers often lament consolidation among the providers and use that as a justification to consolidate themselves. Providers lament big insurance companies and use that as a justification for their own consolidation.

And the end of this kabuki dance—this kabuki dance really has gotten us to a large degree in this mess that we are in, but the end of it is culminated in exactly the litigation that Mr. Balto described in Michigan where essentially you had one dominant provider, one dominant insurer, and they were in cahoots with each other. That is what these contractual provisions, the MFN clauses, the anti-steering clauses, really are. It is the dominant insurer saying to the dominant provider we will make sure there are no entries, and the dominant providers saying the same to the insurer. That is where this dance is ending. If either we do not figure out ways not just to address market power but really—and it involves a combination of cooperation among market players and regulators to figure out a way to revitalize competition in this industry.

Mr. BACHUS. Thank you. That is an excellent point. And any input that you can give the Committee, any proposals that some of you even maybe come together and cooperate with some of this because I see a lot of agreement on certain points that are made.

At this time, the Ranking Member of the Committee has waited patiently for several hours and observed, heard all this testimony, and he has now got some questions.

Mr. COHEN. That is my story and I am sticking to it.

Thank you, Mr. Chair. I was on the floor on SNAP and some other things trying to preserve food for hungry children and veterans and people without opportunities otherwise to have a meal. So I thought that was more important. But I am here, and this is very important too.

First, I would like to ask Ms. Pozen a question because I am real concerned about these States that have not decided to expand their Medicaid programs. What will the impact of not expanding Medicaid programs be on hospital revenues and hospital existence in the States around the country and particularly if you know about Tennessee? But in general, will this be harmful to hospitals?

Ms. POZEN. I think when you think about what has been going on in, as I mentioned, this transformation of health care and the idea of the Government payer and those getting into States so that actually there is access to care and that care can be provided, I can only imagine the hospitals in that situation and how they would re-

spond to it. Again, the Affordable Care Act from the AHA's standpoint is about access to care and coordination of care. So without that, I think we will continue to see this fragmented health care system.

Mr. COHEN. In the State of Tennessee, I think we have not decided to expand our Medicaid. Our Governor there has a problem with his Senate, which is catching up. It is at about 1956 I think right now. So it takes time to catch up to the current situation. And I think $500 million we may be giving up a year by not expanding.

Is it true, as it has been suggested, that rural hospitals might have to close because of the failure?

Ms. POZEN. I cannot speak specifically to Tennessee or the rural hospitals in Tennessee, but I do know, as has been mentioned today on this panel, that the rural hospitals do struggle, and these smaller hospitals need inputs and sometimes need a partner, as I mentioned in my testimony. So without adequate funding and inputs, certainly they could struggle.

Mr. COHEN. And how about the public hospitals? We have the Med in Memphis and Nashville General and Erlanger and UTS hospital in Knoxville. Will the public hospitals in general, the ones that serve the people that otherwise do not have insurance—will they suffer greatly too?

Ms. POZEN. Again, I think those hospitals have to be open for business and accept those that come and need care, as was mentioned by one of the Members earlier. And so that certainly affects how hospitals produce and serve if they are doing it for free.

Mr. COHEN. Mr. Joseph Miller, I understand you represent the insurance industry?

Mr. JOSEPH MILLER. Yes, sir.

Mr. COHEN. Can you tell us how much money the industry paid back because of the Affordable Care Act which required that you only spend no more than 20 percent of your money on salaries and profits and advertising, that cost ratio? How much money did you all end up paying back to consumers for overpayment of insurance premiums because they did not come within that 80-20 differential?

Mr. JOSEPH MILLER. I am sorry, Mr. Cohen. I do not have that figure in front of me.

Mr. COHEN. But it would be a considerable amount of money, would it not?

Mr. JOSEPH MILLER. I do not know what you mean by "considerable." I think it went down from the first year to the second.

Mr. COHEN. Yes, because you all were starting to bring your programs because you did want to have to be doing more than 80 percent, starting to conduct yourselves within the parameters of the law and looking better.

What are some of the other reforms that have come upon the insurance? Can you all no longer have yearly caps on an individual's insurance? Is that not allowed anymore?

Mr. JOSEPH MILLER. Annual lifetime limits have been outlawed from the beginning of the ACA. That is right.

Mr. COHEN. And you used to be able to not allow people with pre-existing conditions to get insurance. You cannot do that anymore, can you?

Mr. JOSEPH MILLER. Starting now, yes, in 2014 pre-existing condition exclusions are no longer permitted.

Mr. COHEN. And children with pre-existing conditions—they have already been affected by that. So they are getting insurance. Right?

Mr. JOSEPH MILLER. I am sorry. I did not hear you.

Mr. COHEN. Children.

Mr. JOSEPH MILLER. Children, yes.

Mr. COHEN. And then parents—they used to not be able to keep their children on their insurance until they are aged 26. Can they do that now because of the Affordable Care Act?

Mr. JOSEPH MILLER. Yes. Children up to the age of 26 are permitted to stay on their parents' policies, some I think before the Affordable Care Act, but now it is required.

Mr. COHEN. Mr. Balto, I guess you have probably had a chance to hear all the testimony. I apologize for trying to see that people did not starve to death in our country in the future years.

Are those reforms good? I mean, is it a good thing that people who have pre-existing conditions can get insurance and that insurance companies cannot take over 20 percent of what they take in for profits and advertising and other overhead and that people do not have yearly caps and lifetime caps on their insurance? Is that really good for the people?

Mr. BALTO. Yes. As a public interest attorney who often represents consumer groups, I absolutely think so.

By the way, the number you were looking for was that last year HHS required the insurance industry to return over $12 billion to over 6.8 million consumers.

Mr. COHEN. Can you say that again?

Mr. BALTO. I did it twice when you were not here.

Mr. COHEN. $12 billion to how many consumers?

Mr. BALTO. Over 6.8 million consumers.

Mr. COHEN. Did you say it? Mr. Miller must not have heard you. He did not commit that to memory, but I am sure he has got it down now. That is amazing. That is amazing. $12 billion was returned to American citizens and how many millions of people?

Mr. BALTO. Over 6.8 million.

Mr. COHEN. So they have already benefited from the Affordable Care Act because instead of just paying that to extra profits and advertising and overhead to the insurance companies, it came back to American citizens, and then they could spend that in the marketplace. And the ripple effect on that in the economy—wow, that is pretty strong.

Mr. BALTO. Yes, it would be, and we hope that once the exchanges go live and there is an increase in competition between insurance companies, insurance rates should continue to stay stable or even decrease.

Mr. COHEN. Professor Greaney, what do you think about all this?

Mr. GREANEY. Well, I would make a couple points on the insurance reforms. When you think about it, what the Affordable Care Act has done is say to insurers what you used to do and you did it very well was find good risks by pre-existing conditions clauses and things like that. You did not manage care. You did not force providers to provide cost-effective, quality care. Taking that off the table, turns the tables on competition and says insurers are going

to have to compete to provide better care through the providers they contract with. And when you think about it, some of these things that were taken off the table are things I do not think anybody would bargain for, pre-existing conditions, lifetime limits, and things like that. It is okay for, I think, legislators to say there are certain things that are not going to be in insurance contracts. Let's compete on quality and other matters. And that is what I think the Affordable Care Act did.

By the way, we in Missouri have also declined to expand Medicaid, and my colleagues on the Saint Louis University Law School faculty have accumulated a lot of evidence about the net cost not only to the taxpayer of Missouri but to the government. It is going to cost the government more in pre-existing programs that it could have done away with.

And finally, there is a health care issue in Medicaid expansion. We have actually calculated the number of probable, based on statistics, mortality rates that will occur in Missouri as a result of the lack of Medicaid expansion. People without health insurance will die in greater numbers.

Mr. COHEN. Let me ask you something else. And I forgot about that, that under this program, the donut hole will be eliminated. Is that going to help people in Missouri?

Mr. GREANEY. It sure will. I mean, the donut hole is one of the most oddball contraptions ever designed. It was a compromise in many ways, but it was very hard to make the case that that really improved rational shopping among consumers.

You know, I think co-pays and deductibles are important and they can serve a purpose, but in many ways co-pays and deductibles can have a bad effect. And there is a lot of academic literature out there, studies, that show people making decisions under the pressure of economic constraints through co-pays and deductibles. They do change their behavior. Unfortunately, the studies also show they are just as likely to forgo unnecessary care as needed care.

Mr. COHEN. Even for a small co-pay.

Mr. GREANEY. Even for a small co-pay. In the Medicaid context, that is certainly true. Small co-pays can do——

Mr. COHEN. So like under this——

Mr. GREANEY. Co-pays can be targeted, however, Congressman. They could be targeted in areas where it makes sense and the consumer can make that tradeoff. It is no so clear the consumer can make that tradeoff when the doctor says you need an MRI.

Mr. COHEN. In the Affordable Care Act, if you go in to your doctor and you should get a colonoscopy because you turned 50 or you have gone 10 or so years after that, there is no co-pay now. Is there?

Mr. GREANEY. No. The Affordable Care Act rightly eliminated co-pays for preventative services.

Mr. COHEN. And mammograms?

Mr. GREANEY. And did exactly that for that very purpose. Those are the kind of decisions that should not be affected by the financial constraint because they are so important.

Mr. COHEN. And then it costs more money later because if they develop this illness and it costs more money later. Preventative

care can save money in the long run. I am even more happy that I voted for the Affordable Care Act today than I ever was. Thank you. This has been a great hearing and I appreciate your testimony.

Mr. MARINO [presiding]. I think that we have time, if you have time, to have another round. I have a couple of questions I would like to zero in on.

Like my good friend here, I have to go down and vote against SNAP because of all those who do not want to work and want the government to keep them at a cost that is just doubling and tripling. But be that as it may, we still have a good relationship.

Mr. COHEN. We do.

Mr. MARINO. Mr. Balto, I am a little confused on the figures that you threw out now, and I think my colleague says that based on what you said, that $12 billion has been paid back to individuals, and in your testimony you said $1.2 billion. Can you help me out?

Mr. BALTO. I misstated it. Thank you, Congressman. It is $1.2 billion.

Mr. MARINO. Okay. It is still a lot of money. So maybe we can take that $1.2 billion and put it into Medicare where the President took out $500 billion and moved it over to Medicaid, which would help our seniors. So we both have a cause here.

Mr. Thomas Miller, can you please—I am going to throw this thought out. I have rural hospitals and municipal hospitals that tell me that the 80-20 setup is not working for them, and that is one of the reasons they just cannot afford to keep operating under the premise. Now, I am a capitalist. I believe the market will determine what prices are. I have a daughter with a pre-existing condition which is causing me a problem now because of Obamacare. And what do we do when the hospital says we are going to go out of business if we do not merge with a larger entity?

Mr. THOMAS MILLER. Well, given your premises, I mean, there are situations in which small hospitals do not have capacity to be effective, efficient operators. That is an issue for the particular case as to what the economics look like. So I cannot give you an automatic reaction to it on that alone. And we certainly do have some small hospitals that have been in that situation, and they have been rolled up into larger chains. I am not quite sure what else you are asking beyond that.

Mr. MARINO. Well, they are still in existence. The point I am getting to, particularly in my district, is these smaller hospitals are still in existence even though they have merged. And so someone does not have to go 50 miles away from their home to get to a hospital. If it were not for the merger, it would be a 30 or 40 or 50 mile trip to get to a hospital even for emergency purposes. Now, we do have EMT's and people that can sustain life, but it is quite a distance to travel.

Mr. THOMAS MILLER. Well, we are certainly looking toward improvements in the ability, whether you want to talk about telemedicine. We have had employers literally paying their folks to travel further to centers of excellence. So there is a shaking out on that as to what is a more efficient economic operation, although we know that patients have an underlying natural bias to want to be

close to home when they look for a hospital, and that has shown up in most referral patterns.

Mr. MARINO. There are parts of Obamacare that I had been promoting even before I came to Congress—I was in government and I was a prosecutor for years—simply because of my daughter's condition. But given the fact that it appears at this point—let's forget about the antitrust side of this for a moment and the merging—that there are going to be a fair number of hospitals that will go out of business. Particularly in my area, we are going to have a problem obtaining qualified nurses and physicians to come into those areas. So how do we compensate for that if the merger is characterized as being just this dangerous monster that is going to increase the cost of health care, which Obamacare is doing? I mean, the insurance companies, the health care providers are telling me about this.

Mr. THOMAS MILLER. Well, I am not assuming up front that necessarily those mergers are bad or dangerous under the circumstances that you have described. The flip side of this is that we have tried this for years in many areas to try to chase after it with additional subsidies. That has diminishing returns over time, and it turns out we run out of subsidized money and then we have done some other sets of distortions.

So what we are really thinking about is a different type of health delivery system landscape in which the people who need services can find them in other means if it turns out the existing institutions cannot serve them as well as they would like to in an economic manner. The more we can break down some barriers to having those type of transformations occur, the better off we will be in getting to that resorting.

Mr. MARINO. I apologize for walking out and coming back. I had another Committee hearing going on and we were doing a markup and I had to vote.

But as I was coming in, did I hear a conversation concerning payment based on outcome? Would anyone like to explain that to me? Because it seems a little strange when you say "payment based on outcome." I am not being facetious, but I am going to exaggerate a point here.

A patient goes in the hospital. Everything is fine. The surgery went well. And then for some reason, the patient passes away. So what do you do based on that outcome?

Mr. RICHMAN. The measurement of health outcomes is a very complicated science, but it is a science that is getting very good. And there are certain things that are easy to measure, certain preventable outcomes like infection rates that are easily prevented, and unnecessary readmissions is another. And the approach among payers, private payers and also Medicare, is to increasingly try to put pressure on providers to avoid avoidable adverse outcomes like infection rates. And the result actually has been a reduction in certain rates.

And it is a bit of an embarrassment that American hospitals still boast higher infection rates and other avoidable problems than our colleagues in other OECD nations. It is not because American physicians or American hospitals are worse than other hospitals, but I think it is because the payment system really does not incentivize

them to look for avoidable measures that are costly ultimately to Medicare and also to insurance subscribers.

Mr. MARINO. Thank you.

Ms. Pozen, please.

Ms. POZEN. Could I add a little bit to that as well?

Mr. MARINO. Yes, please.

Ms. POZEN. Because I do think one of the things, to address some of the issues that we have been talking about—and we have talked a little bit about accountable care organizations or what we call in antitrust clinical integration and this notion of allowing the providers actually to work together to coordinate their care for a given patient so that when a patient comes in, that group of physicians knows here is my checklist based on what I know is likely that I can apply. It is easier for the hospitals and physicians to establish those not only because they are serving that population, but also everyone that comes in is insured either commercially or from a private payer and you do not want to have different checklists.

So I would say having the provider community own this issue in a sense and owning it through the creation of accountable care organizations that have proper integration and have these kinds of protocols established can help in a large part to end again this fragmentation of health care to provide the kind of efficiency and quality care that I think we as Americans hope for.

Mr. MARINO. Mr. Greaney?

Mr. GREANEY. Chairman, I once heard a CEO of a major system—it may have been the Mayo system—say it does not pay to be good. An example would be readmissions. If you have a lot of readmissions that are preventable as a hospital, you get paid twice. If you do not, you only get paid once. That is sort of a simple outcome measure but it is one.

Medicare is looking at value-based purchasing, as it calls it. And again, it would be facilities that have measurable bad outcomes like infectious disease rates, et cetera because none of us want to pay for something we did not get. And I think that is just a sensible way of doing business, and I think private payers are going in that direction as well.

Again, remember, Medicare payment is the tail that wags the dog or vice versa in that the way Medicare pays often leads the way for private payers. So what these reforms are doing in Medicare are changing the way payment is made and delivery occurs.

Mr. MARINO. Thank you. I think we need to develop a hybrid here.

Mr. THOMAS MILLER. If I could just say, most of our quality measurement in the past and even currently has tended to be process measures. We think if you do something, it will create a good result. There are efforts—and they need to be pushed further—to begin to move toward actually measuring what matters to people which is their outcomes. Now, sometimes it may be an intermediate marker. It might be a lab test. There are the no-brainers, which is how to eliminate the infections and the readmissions, but that is not a large enough scale.

I think there has been some progress under the law in CMS in trying to make more available the wider database, particularly Medicare data, to make that more accessible for other folks to

begin to analyze that and come up with something. But it is a matter of probabilities. It is not certainties. We have two competing views which is if we just tell you what to do in a certain manner, good things will occur as opposed to saying why don't we actually see whether or not you are producing something that works. There might be some ways to get there. And that is the difference in terms of those two approaches to measurement.

Mr. MARINO. Thank you.

The Chair now recognizes Congressman Cohen.

Mr. COHEN. Thank you, sir. I appreciate it.

Mr. Balto, you obviously missed a decimal. Was it $1.2 billion that has been paid back to red-blooded, hardworking, good American citizens?

Mr. BALTO. Yes.

Mr. COHEN. And how many millions of people was that?

Mr. BALTO. 6.8 million.

Mr. COHEN. That number has not changed. 6.8 million people got refunds. That is great. That is $1.2 billion with a "B" monies paid back. How many million?

Mr. BACHUS. I thought he said 8 billion.

Mr. COHEN. Are you Johnny Manziel? [Laughter.]

So, Professor Greaney, let me ask you a question. You are an antitrust expert. Right?

Mr. GREANEY. I have been toiling in that vineyard for a lot of years.

Mr. COHEN. And you know something about mergers. Apparently this has been going in some of the hospital industry.

Mr. GREANEY. Yes.

Mr. COHEN. Hasn't this been going on for a long time?

Mr. GREANEY. Yes. I left the Antitrust Division in 1987, and there were challenges then. And what happened going back was a series of several cases which I think a lot of economic studies now prove were wrongheaded. Courts defined very large markets, allowed mergers to go through. And then the enforcers got cold feet and stopped bringing merger cases involving hospitals. What that precipitated was a real wave of hospital mergers in the 1990's and early 2000's. So it was a bringing together of both questionable precedents and a lack of willingness to go forward.

Mr. Balto said we have had retrospective studies and others that I think have changed matters, and right now the FTC is pursuing a number of important merger cases with greater success.

Mr. COHEN. And so those mergers started, you say, in the 1980's and the early 1990's?

Mr. GREANEY. The challenges to the mergers did, yes. And there were rampant mergers in the 1990's, yes.

Mr. COHEN. That was before Barack Obama was even a State Senator.

Mr. GREANEY. That is correct.

Mr. COHEN. It is amazing.

And there have been a lot of mergers in the airline industry, has there not?

Mr. GREANEY. There have.

Mr. COHEN. And in the supermarket industry?

Mr. GREANEY. I believe so, yes.

Mr. COHEN. And department stores.

Mr. GREANEY. Yes.

Mr. COHEN. So there is nothing unique about hospitals per se in a way. I mean, hospitals, airlines, grocery stores, department stores—mergers have been commonplace in America in all areas independent of the fact that Barack Obama was even around or that the Affordable Care Act was passed because the Affordable Care Act had nothing to do with Northwest and Delta getting together or Macy's buying out Goldsmith's in Memphis and I do not know who they bought in St. Louis. Do you still have a regular home department store in St. Louis?

Mr. GREANEY. We do. We have several department stores left, but there have been mergers there as well.

Mr. COHEN. And Schnucks came to Memphis and then they "schnucked" us out and sold to Kroger's who has turned out to be a good group.

Mr. GREANEY. Well, we had an interesting FTC case involving the Schnuck's merger in St. Louis that did not turn out so well.

Mr. COHEN. And all that had nothing to do with the Affordable Care Act, did it?

Mr. GREANEY. It did not. What I think has precipitated some of these mergers is the attempt to sort of gain ground by preemptively merging so they do not have to face competition.

Mr. COHEN. And Mr. Miller, the insurance Mr. Miller, I just want to make sure you did not get $12 billion in your mind. You got $1.2 billion.

Mr. JOSEPH MILLER. Yes. We are checking on the number.

I do want to address the point you are making on the medical loss ratio.

Mr. COHEN. Yes, sir.

Mr. JOSEPH MILLER. It does nothing to address the issue that we are talking about in this hearing, the underlying cost of care.

Mr. COHEN. It has a lot to do with the bill, though, the Affordable Care Act, and that is what this is all about. In this House that I serve in the 113th Congress, 40 times there has been an attempt to repeal Obamacare, and now there is a possibility of shutting down the Government, which John Roberts upheld as the law that the Congress passed and the Senate passed and the President signed. And the President is not going to sign any kind of repeal bill and the Senate is not going to see it. And that is what this is about.

Mr. JOSEPH MILLER. Yes, as far as that goes, AHIP tries to stay out of politics.

Mr. COHEN. Good move.

Mr. JOSEPH MILLER. But I did want to talk just for a minute about the MLR. Everything that health plans do to add value is penalized under the MLR. Formation of high-value networks, care coordination, coordination of medical homes, population health management, and most fraud deterrence expenditures are penalized. They are on the wrong side of the ratio. And so things that we could be doing to help hold down costs were deterred under the MLR.

Mr. COHEN. Mr. Balto, do you have a response to that?

Mr. BALTO. Look, I think the Affordable Care Act appropriately looked at insurance company operations. I did not recite all the testimony delivered in the last Congress about problems in the health insurance market. There were very serious problems, you know, escalating premiums, a huge number of uninsured. It was appropriate to go and look at what was going on and impose certain types of regulation. Those regulations—hopefully 5 or 6 years from now we will not need those regulations because the exchanges will have made the market more robustly competitive and there will not be this kind of padding that is going on.

I do want to go back to your question, does the Affordable Care Act cause the problems in the market. I just want to caution here. Insurance companies and PBMs will knock on the FTC's door and say please let us merge. You need us to get bigger because the drug companies are getting bigger or the hospitals are getting bigger. Going and creating some bigger entity to try to bargain with another big entity always harms consumers. It ends up costing consumers.

Mr. COHEN. Thank you, sir.

And I yield back the balance of my time.

Mr. MARINO. Thank you.

The Chair recognizes the Chairman of the full Committee, Congressman Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman, and I want to thank you and Chairman Bachus for holding this hearing.

And I just want to ask Thomas Miller if—we have had some discussion here about the fact that consolidation takes place in the natural order of things and in other industries for other reasons. But I would like to come back to whether you think that Obamacare by itself has the prospect of more consolidation because of this new health care law and why that would be.

Mr. THOMAS MILLER. I do. I think that there is less opportunity for further consolidation in the hospital industry in light of what has already occurred. But certainly we are seeing, in terms of the integration and consolidation—we are not sure whether it is true clinical integration, which is the outstanding question in a lot of the ACO's. But in general, among physicians and other medical practitioners, they are selling out and being bought up, saying I have got to have some shelter in the larger organization.

Now, we have got limited evidence on what the ACO's are really producing. We had the early results from the pioneer ACO's where it is a little hard to find many cost savings coming from the early going. This is in keeping with many of the previous demonstration projects or other pilots that CMS has done in this field. We got a lot of promises of efficiencies in integration, but the actual delivery indicates a little bit more of a mixed record. We are not sure who is really running the show. What we do know is that consumers often are not asked whether they want to participate in the ACO. So it is more for the other parties about it.

There is a longer-term dynamic. I think it is early to say what is happening in the health exchanges. I was just looking at a study by McKinsey last night suggesting there are two different types of reactions between whether or not the exchanges are being run by the States, which are a little more enthusiastic in recruiting a lot

of insurers to participate initially, as opposed to the default federally run exchanges or even the partnerships where there is less participation. The big insurers are staying out in year one more so than what have been predicted. We are getting a lot of the Medicaid insurers trying to leverage up and provide Medicaid-like products with more limited networks and lower reimbursement as a way to be the low-cost bidders in the exchanges. So I think it is hard to say where those exchanges are going to be a couple of years from now, but in all likelihood, as we have seen before, the folks who get the market share early tend to hold onto it and there is going to be less switching in subsequent years.

So the story of this widespread, competitive dynamic with everyone having every choice in the world—I would suggest you take a look at the New England Journal of Medicine article by Henry Aaron and Kevin Lucia suggesting this is just the beginning. We really want to clamp down on this stuff and be much tighter in terms of what we are going to allow with more active purchasing. Those tools are there under the ACA, and I think if they can get out of the initial bumpy road, extremely bumpy road, of implementation, we may see a different face as to how those exchanges are actually run.

Mr. GOODLATTE. And in terms of pricing of health care and health insurance, more Government subsidies, it would seem to me, are likely to not result in better price control but actually greater demand not being readily met, resulting in higher prices for health care.

Mr. THOMAS MILLER. The Government is good at usually increasing demand. It is a little harder at increasing supply. That is why I certainly think some of the proposals here to expand in more creative ways supply, such as eliminating some of the barriers to entry by other types of providers of health care services, will be necessary. But we are going to run out of enough physicians.

Let me just allude briefly. You know, Medicaid expansion. Speaking of Tennessee, I think they already had their experience with a large expansion in terms of what happened to their health care market. So sometimes you can invite a lot of people in the front door and end up wrecking your system because you cannot actually handle the capacity of what seem to be those demands.

Mr. GOODLATTE. And you may price other people out of the market. Is that not a possibility? Are we seeing a reaction from a number of fronts that the fact that the Government is going to standardize the health insurance policies, that that is going to have an upward force on pricing that is going to cause some employers to push their employees into the exchanges? It is going to cause others to only hire part-time employees, others to not grow their business above 50 employees. Young people who are going to have to pay higher rates because of the community rating that is involved here are going to get priced out of the market. I think a case could be made that there may be as many people losing health insurance as there are gaining health insurance from the new Government subsidies and expansion of Medicaid, pushing people from a place where they have earned health care through their own work into a place where they are dependent on Government for providing it. Is that a good competitive environment?

Mr. THOMAS MILLER. Well, we are having pseudo prices as opposed to real prices. So people react to whatever they see in front of them. Certainly the record in terms of the posted premiums and the analyses as to what these exchanges are going to offer—they are all over the lot. People are actually somewhat guessing because they do not know who is going to enroll, whether the exchange is going to work as well, whether you are only going to get the higher risks and what people are going to be willing to pay for it. We do not have the answer to that, but there is enough reason for alarm.

And one of the better indicators is what State and local governments are doing. They are getting out of the insurance business. They are cutting back on their full-time workers. They are the folks who are most squeezed on their budgets, as other budgets may be squeezed in the future. And normally in that environment, what you were promised does not end up getting delivered. It turns out it is a lot less, and it starts looking a lot more like Medicaid, which has already got enough problems in its current size without trying to put it up on steroids.

Mr. GOODLATTE. And I noted last week that IBM, one of the largest and most successful corporations in American history, announced that they were going to put all of their retirees, 110,000 of them, into the exchanges. Is it possible that we are going to find that many businesses find the cost-benefit analysis here says it is cheaper to put into the exchanges than it is to continue to provide ever-rising costs of health insurance and that the exchanges are going to wind up with more people than intended and the penalty that employers and individuals are—or was it a tax? I cannot remember what the Supreme Court said. Oh, actually they said it was both a penalty and a tax.

Mr. THOMAS MILLER. That is right.

Mr. GOODLATTE. But whatever it is, it is highly likely that it is not going to be enough money to pay for all because, after all, that is why they made the rational decision to be put into the exchange or go into exchange because it was cheaper to do that than to provide for this ever-increasing cost of insurance. Aren't the taxpayers going to get slammed with——

Mr. THOMAS MILLER. Well, we know the taxpayer is the ultimate default payer in most of these arrangements.

Mr. GOODLATTE. Yes, absolutely.

Mr. THOMAS MILLER. Of course, we do not know whether we are going to have an employer mandate. We will just have to guess on that for another year or so. You do not know what law you have until you actually try it out in the field, the same way the individual mandate may or may not have much strength behind it in terms of its impacts as to what its results will be.

What we have got is a different type of insurance and health care market in a lot of turmoil. Employers might want to dump their employees into it if they know it works. They have to see if there is any water in the pool. So we are going to have a very precarious ride over the next year or 2, and we can spin all our theories as to whether it will be better or worse. But we do not know. We are taking a pretty large leap.

Mr. GOODLATTE. Thank you very much.

And by the way, Mr. Chairman, a hospital in a rural area in the congressional district right next to mine announced just last week that they are closing, and the number one reason they are closing is the uncertainty caused by the economic environment and they listed Obamacare as their number one concern.

So I thank you very much, and I yield back.

Mr. MARINO. Chairman, do you have an opening statement you would like to submit into the record?

Mr. GOODLATTE. I will do that as well. Yes, thank you.

[The prepared statement of Mr. Goodlatte follows:]

Last year, as Chairman of the Subcommittee on Intellectual Property, Competition, and the Internet, I conducted a hearing to examine the competitive impact of Obamacare and to express my concerns with Obamacare's disruptive impacts on the health care marketplace. My concerns with Obamacare have not abated since that time. In fact, they have only been heightened.

Without question, the enactment of Obamacare has prompted increased consolidation in the health care industry. In the year following Obamacare's passage, hospital mergers jumped up by 45 percent and have continued to increase year after year, with

105 mergers occurring last year compared with only 53 in 2009.

This trend is unlikely to slow as Obamacare continues to be implemented. Indeed, a recent financial report predicts that up to an additional 1,000 health care facilities may change hands by 2020.

The mere presence of consolidation is not by itself troubling, as there is nothing inherently wrong with merger activity or the formation of large companies. Each transaction should be reviewed on its own merits to determine whether it will yield pro-competitive benefits.

The concerns that I raised last year, and continue to hold this year, focus on the displacement of the will of the market by the judgment of the federal

government. Obamacare was enacted in a climate of high density in the health care marketplace, and, rather than dismantle barriers to competition, the law only intensified the trend of consolidation.

One of the principal tenets of economics is that competition can lead to lower prices, enhanced product variety, greater innovation, and downward pressure on costs. As markets consolidate, there is a risk of reduced competition resulting in the contraction of the related benefits.

Accordingly, it is vitally important that antitrust laws are properly and consistently enforced to prevent anticompetitive consolidation and conduct, and that laws that promote these activities are subject to strict and ongoing scrutiny. Continuous and

vigilant oversight, such as at today's hearing, will help to ensure that health care markets operate freely and competitively in order to provide consumers with premier and affordable health care.

I am pleased that the Chairman has continued to focus on this very important issue, and I look forward to the testimony of all of our witnesses. Thank you Mr. Chairman, and I yield back the balance of my time.

# # #

Mr. COHEN. And I would like, with consent, to introduce my opening statement for the record.

Mr. MARINO. Without objection.

[The prepared statement of Mr. Cohen follows:]

Prepared Statement of the Honorable Steve Cohen, a Representative in Congress from the State of Tennessee, and Ranking Member, Subcommittee on Regulatory Reform, Commercial and Antitrust Law

I thank Chairman Bachus for holding today's hearing on the impact of the Patient Protection and Affordable Care Act on consolidation and competition in the health care industry. I hope that we can have a serious discussion on the important antitrust issues before us today.

As all of our witnesses have outlined in their written statements, consolidation in the health care industry has been going on for some time, long before the ACA's enactment. In both the hospital and insurance sectors, we have seen substantial consolidation.

With respect to the hospital sector, we have seen numerous studies suggesting that such consolidation among providers may have resulted in increased prices, although some challenge that conclusion.

We have seen far fewer studies done on the substantial consolidation in health insurance markets, though the effects of such consolidation have been highly detrimental for consumers.

According to a May 30, 2013 memorandum released by the Obama Administration, in 2012, the individual insurance market was dominated by one or two different insurance companies in most states.

In 11 states, the largest two issuers covered 85% or more of the individual market. In 29 states, one insurer covered more than 50% of all enrollees in the individual insurance market, and in 46 states and the District of Columbia, two insurers covered more than half of all enrollees.

At least one recent study has shown that such concentration among health insurers has caused average premiums to rise by 7%, or about $4 billion.

Lax antitrust enforcement during the Bush Administration against health insurance companies was part of the problem. As David Balto, one of our witnesses, has noted, during the previous Administration "there were more than 400 health insurance mergers brought before the DOJ, only two of which required restructuring."

While I am heartened to see that the enforcement agencies have stepped up efforts to stop anti-competitive mergers in the last few years, such efforts may not be able to entirely undo the harmful effects of already consummated mergers.

In recognition of this fact, the ACA takes a number of measures to improve consumer choices and the quality of health care.

Most prominently, the ACA requires the establishment of Health Insurance Exchanges or Marketplaces. These Marketplaces will serve to foster competition by facilitating the offering and purchasing of health insurance by pairing a large and stable risk pool with a number of health plans competing for their business, whether on price or coverage or both.

The ACA also prohibits certain anticompetitive practices by health insurers, including cherry-picking only the youngest and healthiest policyholders and keeping a disproportionate amount of revenue from premiums for profit rather than using it for policyholders' health care-related issues.

The ACA also recognizes that not all coordination or integration among health care providers is bad. In fact, as most of our witnesses appear to acknowledge, such integration and coordination can be procompetitive.

For instance, the ACA encourages the formation of Accountable Care Organizations. This is because our current health care delivery system is fragmented and our health payment system incentivizes quantity over quality. If structured properly, ACO's can overcome these problems by encouraging health care providers to share relevant information with each other that can result in more efficiency, better quality care, and cost savings.

To the extent that the premise of this hearing is that the ACA will encourage anticompetitive consolidation, I note that two different Commissioners of the Federal Trade Commission have noted in recent public remarks that there is no inherent conflict between the ACA and antitrust law.

Commissioner Julie Brill—a Democrat—noted that the argument that "the ACA encourages providers to 'consolidate' whereas the antitrust laws require that providers 'compete' is mistaken. The ACA requires providers to create entities that co-

ordinate the provision of patient care services. The ACA neither requires nor encourages providers to merge or otherwise consolidate."

Similarly, just last Friday, Commissioner Maureen Ohlhausen—a Republican—stated that "the antitrust laws and the [ACA] are simply not at odds. The goals of the Act include fostering greater efficiencies for patients—that is, higher quality at lower cost—through increased coordination of care, while FTC challenges to anticompetitive consolidations of hospitals or providers serve to protect competition that creates efficiencies and benefits patients."

I hope we keep all of these points in mind as we consider the discussion before us today.

Mr. MARINO. Chairman Bachus?

Mr. BACHUS. Let me just make a comment first of all and then I am going to ask a question.

Anytime we talk about competition, we have to talk about new businesses, new starts because ultimately most competition comes from new ventures or new companies. Traditionally in this country, it has generated probably two-thirds of the growth of our job market. So we are all, I think, very concerned that we do not do anything to restrain new companies, small businesses.

And in that regard, the Small Business Administration, others have taken a look at the cost of Federal regulations, whether you say good regulations, bad regulations, or so-so regulations. The number that the Small Business Administration comes up with is that Federal regulations alone absorb 14 percent of our gross domestic product, or we could say our economy. That is one way of saying our economy. 14 percent. That is not taxes. That is not health care. That is Federal regulation. That is not State and local ordinances. And that figure is outdated because we have had 25 percent more regulations added since that time primarily in the Affordable Health Care Act, Dodd-Frank, and climate control legislation, and increased EPA, the lion's share.

So whether we say the Affordable Health Care Act is a good thing or a bad thing, it increases regulation. There are good regulations. There are regulations that protect us, our safety, our health. So this is not a diatribe against all regulations.

And jobs I think is something that unite all of us. We want better jobs. We want more jobs for our children and our grandchildren. It is affecting our deficit. It is affecting our debt. It is affecting our ability to finance government. It is affecting our ability—a weak economy—our ability to pay for our elder care and health care. It is one reason there is a discussion on the floor today about the level of food stamps.

And we have been having hearings in this Committee where if you can increase the gross national product or grow the economy, you take it from 2 percent to 4 percent, you can add enough jobs to where you are creating close to a million jobs every month. And economically it would be a boon for this country. If you take that 14 percent figure and you try to get out of that one out of seven, just cut the cost by one-seventh, you pick up as much as 2 percent in gross national product because regulations tie up capital, they divert some of the workforce into complying. And obviously, you have got capital plus the workforce or population, whatever, and innovation and productivity. And anytime that you are complying with certain regulations, it reduces productivity.

Every President has said—and this is President Bush, President Clinton, President Obama—we need to get rid of some of the Federal regulations. Not all of them. There are some outstanding ones, some good ones. But none of these Presidents have done that. Every President has added pretty much the same number of regulations, although when these regulations from really the two biggest pieces of legislation in the last 30 or 40 years—it is going to increase tremendously.

So I would just say we all ought to be committed to better jobs, more jobs, higher paying jobs. And one thing we ought to look at, which President Obama has made two speeches on, is let's look at our regulations and let's eliminate some. And I do not think we have eliminated any of them in years.

My one question is certificate of need. I seem to hear a pretty much consensus that certificate of need boards are not a good thing, that they inhibit competition and they drive up the cost of health care. Is that basically the consensus? Can I have a show of hands that believe they are not a good thing?

Mr. RICHMAN. That they are not a good thing?

Mr. BACHUS. Not a good thing.

We have one in Alabama. I truly believe it is not beneficial. So I do see some agreement here. And that is something for States to address as we look for savings.

So thank you very much for the hearing today, and I will yield back to the Chairman.

Mr. MARINO. Thank you, Chairman.

This concludes today's hearing, and I want to thank our witnesses. It was a good, lively discussion. I actually wish we had more time.

I want to thank the people in the audience for sitting through this and listening to this exchange.

And without objection, all Members will have 5 legislative days to submit additional written questions for the witnesses or additional materials for the record.

This hearing is adjourned.

[Whereupon, at 3:05 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Ranking Member, Committee on the Judiciary, and Member, Subcommittee on Regulatory Reform, Commercial and Antitrust Law

The Affordable Care Act makes critical reforms to our Nation's health care system and will help millions of uninsured Americans to gain access to affordable health insurance.

Today's hearing considers the impact the Act may have on competition in the health care industry among both health care providers and health insurance companies.

My principal objective is to ensure that consumers will be the primary beneficiaries of these reforms through lower prices and better health insurance coverage.

To begin with, I share with my friends across the aisle concerns about the detrimental effects that consolidation in the health insurance market can have on our ability to achieve this objective.

But let us be clear. Consolidation in the health insurance market has been occurring at least since the 1990's.

A major reason why this has occurred is that the health insurance industry has enjoyed almost complete immunity from the antitrust laws through the McCarran-Ferguson Act of 1945.

Thanks to this exemption, insurers have been allowed to run roughshod over consumers and care-givers.

That is why I introduced H.R. 99, the "Health Insurance Industry Antitrust Enforcement Act of 2013," on the very first day of the 113th Congress.

My legislation would repeal the McCarran-Ferguson antitrust exemption for health insurance companies with respect to price-fixing, bid-rigging, or market allocations, the worst kinds of anti-competitive conduct.

This legislation should enjoy broad bipartisan support based on the fact that the House passed a similar bill during the 111th Congress with more than 400 votes.

Accordingly, I would very much welcome the Majority's assistance in bringing this measure to the Floor again.

The problem is compounded by the fact that although most of the Nation's health insurance markets are disproportionately dominated by only a handful of powerful players, enforcement actions challenging consolidation in the health insurance market were rare until only recently.

The Justice Department, for example, has finally taken action against Blue Cross Blue Shield of Michigan because of its dominance and conduct in my home state.

In addition, the Department has recently brought actions against insurers in other states.

Federal antitrust enforcement, however, has been, on the whole, insufficient. Most markets are dominated by one or two plans.

Our regulating and enforcement agencies must continue to enhance their efforts to prevent incumbent, dominant insurers from hampering competition through exclusionary or collusive conduct.

I believe, however, that the Affordable Care Act's provisions for Health Insurance Marketplaces will encourage new insurance companies to enter this industry.

The barriers to entry to starting new insurance companies or entering new markets are extremely high, and these market concentrations, in turn, have pushed hospitals to claim the need to merge in order to effectively negotiate with the major insurance plans.

These Marketplaces will help foster competition with existing insurers and potentially allow for new and innovative players to enter the market.

Just this past Tuesday, the Department of Health and Human Services released a report showing that about 6.4 million Americans who are eligible to buy health insurance through the new Marketplaces will be able to obtain health insurance for less than $100 a month in premiums thanks to tax subsidies.

And, according to HHS, health insurance premiums will be 20% lower in 2014 than initial estimates suggested thanks to these new Marketplaces.

The quality of insurance plans offered through the Marketplaces will also be better for consumers, as the Affordable Care Act requires these plans to provide certain minimum coverage.

And, the Act prohibits insurance companies from cherry-picking only the youngest and healthiest individuals to sell policies to, among many other reforms.

Some have suggested that the Act may further promote healthcare consolidation, particularly through its encouragement of the establishment of accountable care organizations and minimum loss ratios, among other things.

They ignore the fact that these features have the potential to be pro-consumer, providing better health care quality and efficiency. Moreover, given that they will not come into effect until 2014, the conjecture about their anti-competitive effects is premature.

More broadly, our privatized healthcare system, by its nature, creates an innate tension between increasing shareholder profits, on the one hand, and improving access to quality health care, on the other.

This is precisely why our Nation ultimately needs a single-payer system.

Basic economics would suggest that with fewer market participants, the incumbent firms will eventually end up exercising market power with no countervailing benefits for consumers.

The ultimate question in antitrust, however, is whether conduct results in net harm to consumers. To the extent that conduct results in net benefits to consumers, it should not run afoul of the antitrust laws.

So the real challenge is whether the Act will be implemented in a way that will mitigate some of the negative effects of consolidation in the health insurance and provider markets while also maximizing the pro-consumer benefits of greater integration and coordination among providers.

Because implementation of the Act is still in its early phases, and because major pieces of the law will not come into full effect until 2014, we have the opportunity now to influence how it is implemented to increase competition, quality, and access to care.

Questions for the Record from Chairman Spencer Bachus
for the Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care"

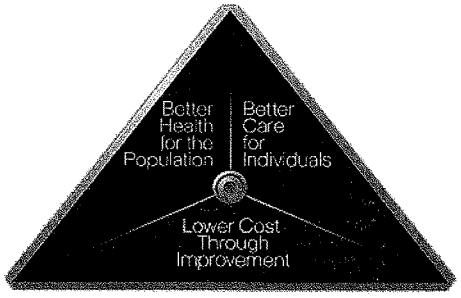
September 19, 2013
Questions for AHA Witness Sharis Pozen

1. You state that there may be a concentration within the health insurance marketplace. Why do you believe that to be the case, and what impact does that have on rate negotiations between hospitals and insurers?

   The American Medical Association reports annually on concentration in the health insurance industry. It's 2013 update reported "71 percent of the 386 MSAs studied were highly concentrated (HHI>2,500) based on the DOJ/FTC Horizontal Merger Guidelines…[a] single insurer's share was at least 50 percent in 41 percent of the MSAs." Such unprecedented monopsony power (the ability to reduce and maintain input prices and retard innovation) adversely impacts consumers and providers. For hospitals, the impact is often to stifle beneficial innovation and force them to accept rates below competitive levels, which has adverse impacts on consumers with respect to access, development and implementation of innovative methods to improve the coordination and quality of care. A 2012 report from Moody's stated "[i]n most markets dominated by larger payors, hospital commercial reimbursement rates are lower than average."

2. You state that the insurance industry is engaged in acquisitions involving hospitals and physician practices. Should we be concerned with those types of transactions?

   Yes. Those transactions should get the same level of scrutiny as other in the healthcare field. Despite some assertions that insurers can act as reasonable proxies for consumers, insurers and consumers often have competing interests with regard to the delivery of health care. As aptly illustrated by the healthcare "triple aim" public and private reimbursement incentives for the hospital field are calibrated to measure and reward quality and efficiency for care of individuals and the community at large. Those same incentives are not routinely present for large commercial health insurers.



3. There are often criticisms levied at hospital mergers and transactions. In your testimony you cite to some examples of positive results from certain merger transactions. Can you provide us with examples of hospital mergers after which the end results were improved efficiencies and higher quality of care delivered to patients?

   The report I referenced in my testimony, "How Hospital Mergers and Acquisitions Benefit Communities" contains numerous examples of how mergers and acquisitions benefitted the community. For many hospitals involved in such a transaction, the infusion of capital made the difference between being viable and closing its doors or drastically reducing services. I attach that report here.

4. Your testimony points to a recent rise in health insurance premiums that are, as you state, "more than double that of underlying health costs." What, in your view, is driving the recent increase in health insurance premiums?

   The AMA report referenced above, links pervasive concentration in the health insurance industry with higher premiums. It cites several studies, including two that examined specific transactions – Aetna and Prudential and UnitedHealth and Sierra Health Services – and concluded that increased concentration was positively associated with market power and higher prices.

5. Do you think there is a potential for competitive harms to result from the formation of Accountable Care Organizations? How can we ensure that ACOs do not result in only increased market share without the benefit of improved quality of health care? And, to the extent that does occur, would there be any way easily to undo the formed ACO?

   ACOs promise significant innovation in the coordinated delivery of health care services to a population and are widely viewed as a procompetitive innovation. The Department of Justice's Antitrust Division and the Federal Trade Commission issued specific guidance for ACOs, it states [t]oday's guidance will help health care providers form procompetitive ACOs that benefit both Medicare beneficiaries and patients with private health insurance while protecting health care consumers from higher prices and lower quality. http://www.ftc.gov/news-events/press-releases/2011/10/federal-trade-commission-department-justice-issue-final-statement

Question for the Record from
Representative Doug Collins

6. The health care industry is currently experiencing many changes and hospitals are getting hit with many new and very costly regulatory requirements, such as health information technology, and quality improvement and value-based purchasing programs. While these programs are important, do you think this may spur hospital realignment to help ensure that these programs are able to achieve their intended goals?

   There are a number of public and private forces that are spurring realignment. The document attached "Hospitals" The Changing Landscape is Good for Patients & Health Care" delves into those forces in greater detail.

How Hospital Mergers and Acquisitions Benefit Communities
Updated Study by the Center for Healthcare Economics and Policy

American Hospital Association®

Much that has been written and said about hospital mergers and acquisitions is misleading. What the facts show is that over the past six years, hospitals have responded to private sector and government incentives to provide higher quality and more efficient health care by, among other strategies, partnering with others. Sometimes those partnerships involved mergers with or acquisitions of other hospitals.

The overwhelming majority of those transactions are procompetitive and fully support the twin goals of higher quality and more affordable health care.

Facts: Nearly all hospital transactions have to be reported to the Federal Trade Commission and the Department of Justice's Antitrust Division (DOJ) for scrutiny. Even for those that do not have to be reported, typically because they are smaller transactions, FTC, DOJ and the state Attorneys General have the opportunity to (and often do) investigate if they believe the transaction raises competitive concerns.

Facts: Hospital markets are local. Determining the potential competitive impact of any transaction begins by looking for other hospitals in the area.

The Center for Healthcare Economics and Policy (Center) undertook a comprehensive study to determine just how many hospital transactions there have been since 2007 and how many hospitals remained in a local area following those transactions to provide options for patients in need of hospital care.

The Center measured the impact of these transactions by Metropolitan Statistical Area, which is a geographical region with a relatively high population density at its core and close economic ties throughout the area.

Facts: Between 2007 and June 2013, only a fraction of the hospital field, 607 hospitals or about 12% of community hospitals, have even been involved in a transaction (merger or acquisition).

- The transactions themselves have been modest: the average number of hospital acquired in a transaction was between 1-2.
- Of those hospitals that have been involved in a transaction, ***all but 22 have occurred in areas where there were more than 5 independent hospitals***.That means there were plenty of hospitals left following the transaction to maintain a competitive marketplace.
- Looking more closely at hospitals included within this group of 22, the stories about how the transaction benefitted the community are compelling:
  - 9 of the transactions involved small hospitals with 50 or fewer beds; the type of hospitals that often struggle without a larger partner to supply essential capital or specialized expertise.

FTI CONSULTING

Center for Healthcare Economics and Policy

How Hospital Mergers and Acquisitions Benefit Communities
Updated Study by the Center for Healthcare Economics and Policy

Continued

American Hospital Association

- One of these hospitals (25 beds) was in bankruptcy when it was acquired,
- For another, (25 beds) the acquisition promised construction of a replacement hospital and new services, such as a birthing center,
- For another, (25 beds) the hospital's new partner immediately committed $9.3 million to improve cash flow and develop new services for the county, including a new information system,
- For another, (34 beds) its new partner committed $10 million of new investment over 10 years,
- For another, (50 beds) it was struggling with excess capacity when it was acquired,
- For another, (12 beds) changed federal regulations made it difficult to grow or expand and the hospital likely would not have been able to stay open; plus the transaction was reviewed by the state attorney general.

- For a slightly larger rural hospital (85 beds), the city approved the transaction to "ensure the long-term viability of the community's acute care hospital, long-term care facility and independent living apartments for seniors." Officials noted the challenging regulatory environment facing rural hospitals.
- For a larger hospital, (120 beds) that was struggling financially, the acquisition allowed it to be transformed into a regional Children's Hospital, with improved access and services. The transaction was closely reviewed and cleared, in writing, by FTC.
- For another larger hospital, (99 beds) the transaction resulted in new access to technology and expanded services and a $25 million commitment to a new Wellness Foundation.
- For a larger hospital, (181 beds) it was losing money and had laid off 91 employees the year before it was acquired.
- For another larger hospital, (200 beds) the transaction was reviewed and approved by the state Attorney General: a spokesman reported there were no "antitrust or charitable trust concerns" with the transaction.
- For a rural hospital system the transaction funded replacement facilities for its health department, mental health and employee wellness programs. Prior to the transaction, the parties had a long term lease that the transaction replaced. The county manager described it as a "win-win" for the county.
- For a transaction that involved two different hospitals being acquired at the same time (and was cleared by FTC), one of those hospitals was owned by a corporation that went out of business shortly after the acquisition and the other was suffering from a deteriorating facility, decreased patient volumes and various financial challenges.

The numbers of and the stories behind the transactions demonstrate that mergers and acquisitions are supporting the changing landscape of health in a positive way.

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Center for Healthcare Economics and Policy

Hospital Mergers and Acquisitions: 2007- June 2013

September 18, 2013

FTI CONSULTING
Center for Healthcare
Economics and Policy

Overview

The Center for Healthcare Economics and Policy ("Center"), a separate business unit in the Economics Practice of FTI Consulting, Inc.,* was commissioned by the American Hospital Association to conduct a study of mergers and acquisitions over the 6 year period of 2007-2012 ("How Hospital Mergers and Acquisitions Benefit Communities"), and to update the study for the first half of 2013 (June 2013). The study uses information from:

- Irving Levin Associates, Inc., including *The Hospital Acquisition Report 2012-2013*
- Modern Healthcare, *Hospital Mergers and Acquisitions Reports*, 2007-2012
- American Hospital Association, *Healthcare QuickDisc*, 2008, 2010, 2011
- American Hospital Association, *Annual Survey Database*, 2012
- Center for Healthcare Economics and Policy, proprietary research

Update: The updated study was conducted using the same methodology and data sources as the 2007-2012 study. In the first half of 2013, there were 31 transactions involving 55 acquired hospitals. 22 of these transactions involved a single acquired hospital. There were 19 transactions that did not involve an overlap MSA. Of those with an overlap MSA (12 transactions), only 2 were in MSAs with 5 or fewer competitors at the time of the transaction.

*This updated study was conducted by Margaret E. Guerin-Calvert, President and Senior Managing Director, Senior Consultant, Eliot Davila, and Consultants Russell Keathley and Benjamin Spulber.

Number of Transactions and Hospitals Involved in Them Per Year 2007-June 2013

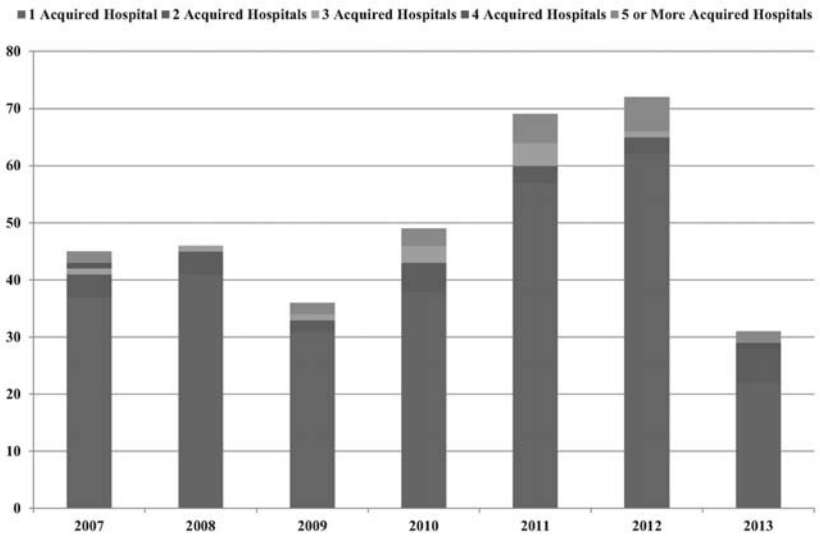
Year	Number of Transactions	Acquired Hospitals: Total Hospitals	Acquired Hospitals: Average Number of Hospitals Per Transaction
Total	**348**	**607**	**1.7**
2007	45	111	2.5
2008	46	52	1.1
2009	36	61	1.7
2010	49	90	1.8
2011	69	107	1.6
2012	72	131	1.8
2013	31	55	1.8

- *From 2007 to 2012, there were 317 transactions,* with an additional 31 transactions in the first half of 2013, for a total of 348 transactions involving 607 acquired hospitals*
- *The average number of acquired hospitals per transaction was between 1 and 2*

**One additional transaction is included for 2012 in this update.*

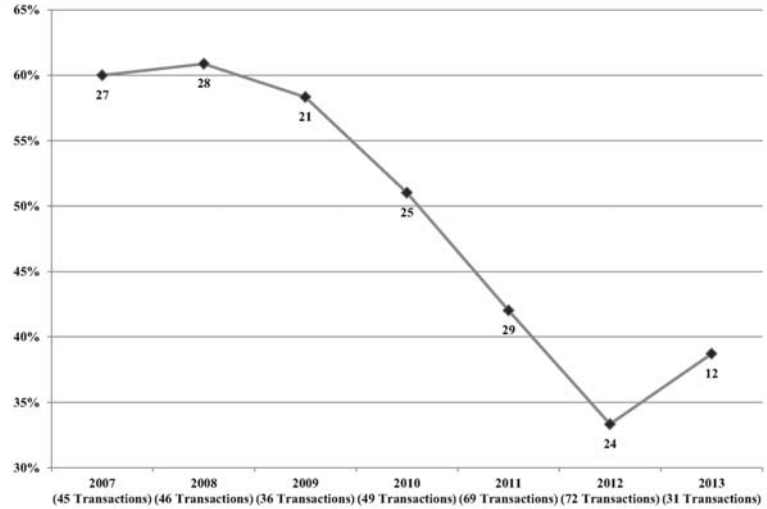
Note: Reported transactions exclude acquisitions by private equity firms or physician groups, vertical transactions, abandoned transactions and other non-hospital-to-hospital transactions. Pending transactions are included.

Frequency of Transactions by Number of Acquired Hospitals 2007-June 2013



- *The majority of transactions between 2007 and 2013 involved a single acquired hospital*

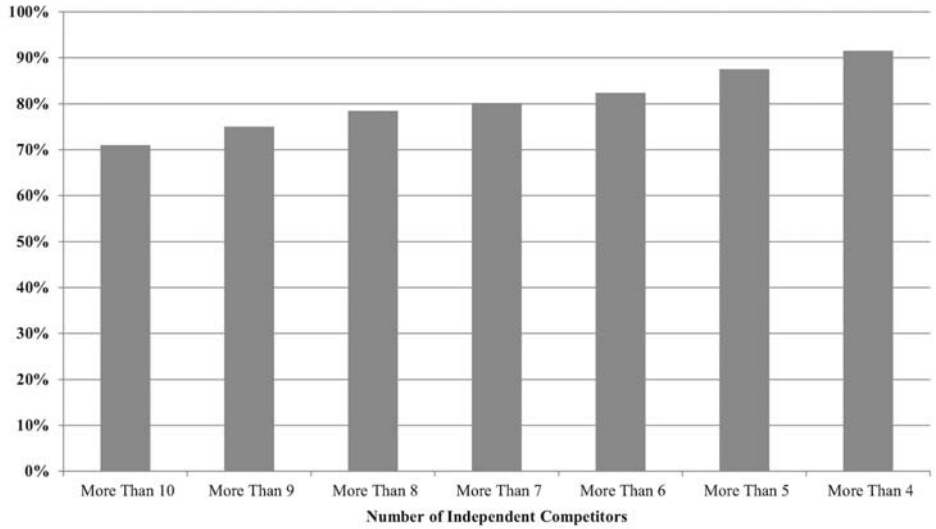
Proportion of All Transactions with an Overlap in One or More MSA*; 2007-June 2013



- *An MSA overlap occurs when both parties in a transaction operate a hospital in the same MSA*
- *The proportion of transactions that resulted in at least 1 MSA overlap fell from approximately 60% in 2007 and 2008 to less than 40% in both 2012 and the first half of 2013*

**Note: The term 'MSA' denotes either a metro- or a micropolitan statistical area*

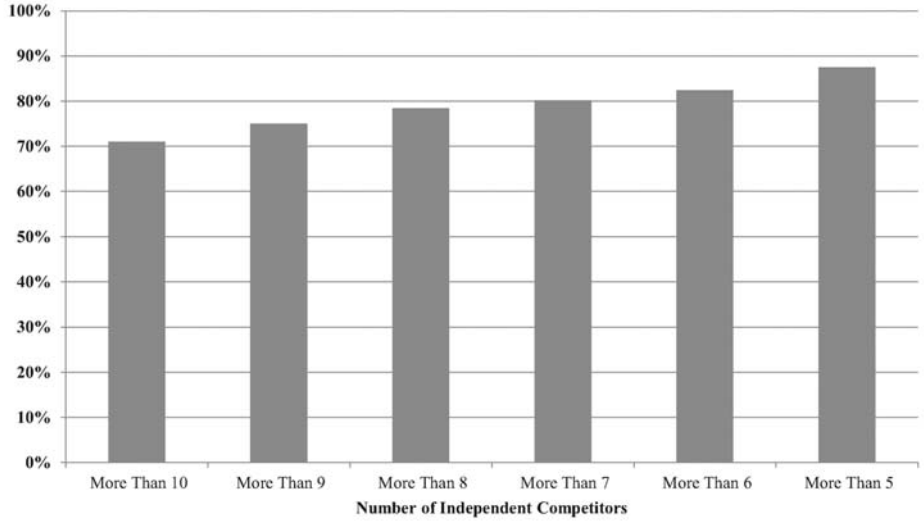
Percentage of MSA* Overlaps Occurring in MSAs with More than 4 Competitors (176 MSA Overlaps in 166 Transactions); 2007-June 2013



- *More than 91% of the overlaps were in MSAs with more than 4 competitors*

*Note: The term 'MSA' denotes either a metro- or a micropolitan statistical area

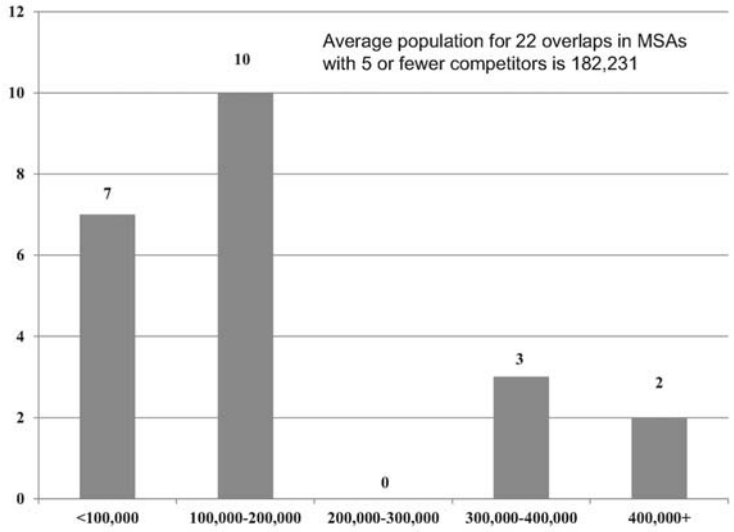
Percentage of MSA* Overlaps Occurring in MSAs with More than 5 Competitors (176 MSA Overlaps in 166 Transactions); 2007-June 2013



- *Almost 90% of the overlaps were in MSAs with more than 5 competitors*

*Note: The term 'MSA' denotes either a metro- or a micropolitan statistical area

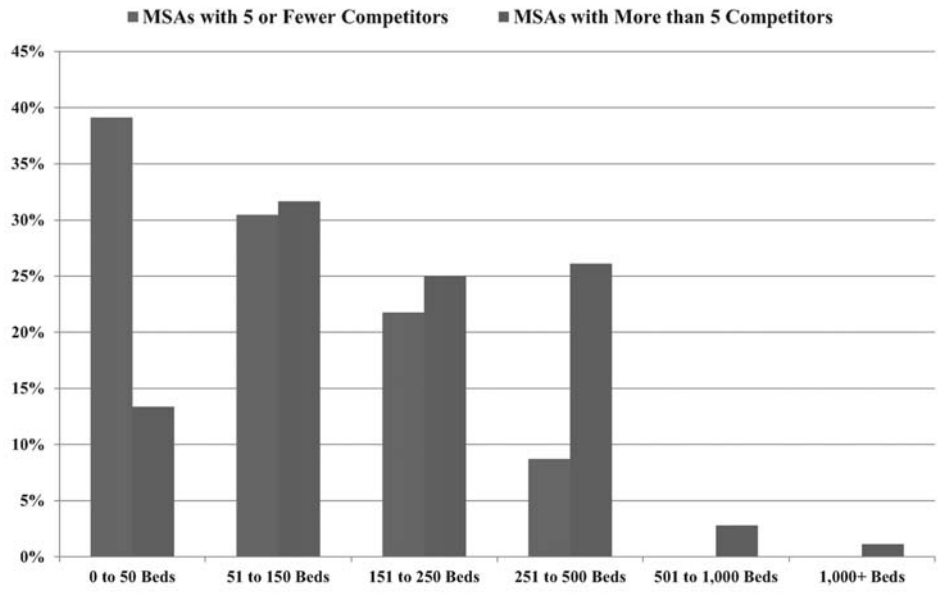
Overlap MSAs* with 5 or Fewer Competitors (22 MSAs): MSA Population and Count of Overlaps; 2007-June 2013



- *22 MSA overlaps occurred in MSAs with 5 or fewer competitors*
- *17 of these 22 MSAs had populations of less than 200,000*

*Note: The term 'MSA' denotes either a metro- or a micropolitan statistical area

Distribution of Acquired Hospital Size in the 22 Overlap MSAs;* 2007-June 2013



*Note: The term 'MSA' denotes either a metro- or a micropolitan statistical area

Distribution of 22 MSA Overlaps by State and Year

State	Year	Acquired Hospital bed Size
California	2013	354
Georgia	2011	41
Louisiana	2008	171
Michigan	2007	181
	2008	99
	2010	34
Minnesota	2011	85
	2012	134
New Mexico	2011	12
New York	2009	199
North Carolina	2008	25
	2013	381
Ohio	2010	25
Oklahoma	2012	45
Pennsylvania	2007	200
South Carolina	2007	41
Tennessee	2012	118
Texas	2007	50
	2009	120
Virginia	2008	135
West Virginia	2010	194
Wisconsin	2011	25

Hospitals: The Changing Landscape is Good for Patients & Health Care

American Hospital Association.

Hospitals: Care Integration for the Right Reasons

Coming on the heels of the recession, hospital merger/acquisition activity began to accelerate. Hospitals began acquiring other hospitals and hiring medical staff in an effort to provide the leadership needed to reform a siloed health care system that nearly everyone from Institute of Medicine to the Medicare Payment Advisory Commission (MedPAC) has singled out as one of the main culprits in higher cost, lower quality health care.

Both government and the private sector are creating incentives that are driving hospitals toward one another and toward their medical staffs with new global and fixed payments; new incentives for meeting quality, efficiency, and patient satisfaction goals (and penalties for failing to do so); and rescinding payments for certain readmissions.

> Both Moody's and Standard & Poor's report a negative financial outlook for hospitals, attributable in large part, to the fact that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed."
>
> *—Moody's Outlook 2012*

> "[H]ospitals that successfully improve operating efficiencies, engage in growth strategies, and align more closely with physicians will be better poised to adapt to ongoing challenges."
>
> *—Moody's Special Comment 2012*

Meeting these myriad challenges requires building a continuum of care that includes healthier, leaner hospitals and closely aligned medical staff.

> "The ability to demonstrate lower costs while providing higher quality care will be the key driver in governmental and commercial reimbursement going forward."
>
> *—Moody's New Forces 2012*

To achieve these worthy goals, mergers may be the only recourse, as decades old regulatory barriers can keep hospitals and doctors from working closely together to improve care and reduce costs unless they are under the same ownership umbrella. Gainsharing demonstration projects in New Jersey, for example, show care and cost improvements from closer collaboration, yet the barriers remain.

> "We believe physician employment … will continue to grow because of the expected incentives … call for tighter care coordination to manage services that are bundled together … or simply to better manage patients with chronic conditions."
>
> *—Standard & Poor's 2012*

Hospitals: Antitrust Watchdogs Prevent Anticompetitive Mergers

Hospitals have been under the watchful eyes of the federal antitrust authorities for decades. When the Federal Trade Commission (FTC) believes a hospital merger threatens competition, the agency has not hesitated to step up.

The FTC alone investigated a dozen completed hospital mergers and challenged or threatened to challenge at least that many proposed mergers in recent years.

New care models, like accountable care organizations (ACOs), will continue to get the FTC's closest scrutiny. In response to a question about ACOs, the FTC's now former chairman said:

> *"We're not going to roll over and play dead and allow a lot of health-care consolidation."*

Not so for insurance companies. Over the past decade, no merger between major insurance companies has been completely rejected by the federal antitrust authorities. Indeed, as well documented annually by the American Medical Association and observed by others:

> "[I]t appears that consolidation has resulted in the possession and exercise of health insurer *monopoly* power ... instead of passing any benefits of consolidation such as lower premiums from efficiency gains on to consumers .... [T]he majority of health insurance markets in the United States are highly concentrated."
>
> *—Competition in Health Insurance 2012*

> "Payers have consolidated over the past several years … providing greater negotiating leverage for the payer."
>
> "In most markets dominated by large payers, hospital commercial reimbursement rates are lower than average."
>
> *—Moody's 2012*

Some payers tend to blame hospital mergers for high insurance premiums. *Two* economic consulting firms examined charges that hospital mergers in the 1990s drove up prices. They said:

"There is no valid empirical basis for [that] conclusion."
—Competition Policy Associates and Economists Incorporated 2003.

That is still true today.

—Continued

Hospitals: Consumer Preference Matters

Like firms in every other sector of our economy, hospitals are not all the same. Some hospitals with high-level or more costly services, like burn or high-level trauma units or other highly specialized care, have higher costs and may charge higher prices. These may also be the very hospitals that consumers most want to go to when they are seriously ill or badly injured.

Pundits often confuse such consumer preferences with market power – they are wrong to do so.

> "Even the FTC acknowledges that for hospitals, different prices are "neither necessary nor sufficient to demonstrate … market power."
>
> *—FTC Working Paper 2009*

Hospitals compete to be the best and invest the resources needed to maintain consumer trust and loyalty.

—Compass Lexecon 2010

In a radio interview, small business owners in California said they were willing to pay more for the hospitals their employees believed were the best.

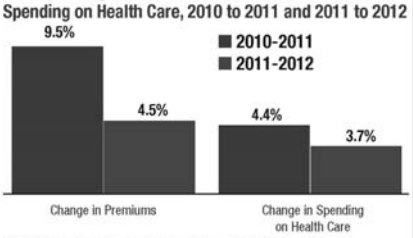
—KQED, November 20, 2010

Hospitals: Price Growth is at Historic Lows

> **Despite renewed merger activity, the growth in spending on hospital care is at historic lows.**
>
> *—Altarum 2012*

It is *not* hospital prices that are driving the rise in insurance premiums. The growth in insurance costs from 2010 to 2011 was more than double that of the underlying health care costs, including hospitals. From 2011 to 2012, premiums began to reflect the lower spending growth, but still outpaced it by nearly 14%.

Percent Change in Premium Levels vs. National Spending on Health Care, 2010 to 2011 and 2011 to 2012



Source: The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits Survey.* Data released 2011. Link: http://ehbs.kff.org/pdf/2011/8225.pdf. Altarum Institute, Insights from Monthly National Health Expenditure Estimates through December 2011. Link: http://www.altarum.org/reasearch-initiatives-health-systems-health-care/altarum-center-for-studying-health-spending/health-indicator-reports.

> **Growth in Medicare spending per beneficiary hit historic lows during the 2010 to 2012 period.**
>
> *—HHS Issue Brief 2013*

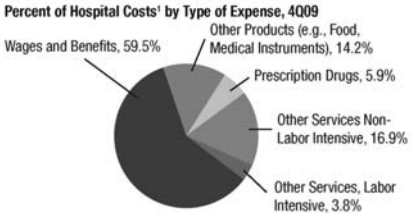
Insurance companies are expected to drive hospital rate increases even lower, according to Moody's, "continuing a multi-year trend."

> "[T]he opportunities to gain leverage and higher rates from commercial payors are quickly dissipating…."
>
> *—Moody's New Forces 2012*
>
> "We expect commercial payers to remain highly aggressive in negotiating lower reimbursement rates with hospitals in 2012."
>
> *—Moody's 2012*

Unlike other health care sectors, study after study has shown that hospital prices are directly related to the cost of caring for patients. Funds needed to hire and retain doctors, nurses and other medical and support staff with the right qualifications and training are the single largest cost for hospitals – they account for two-thirds of total expenses.

About two-thirds of hospital costs go to the wages and benefits of caregivers and other staff.

Percent of Hospital Costs[1] by Type of Expense, 4Q09



Source: IHS Global Insight, Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital Input Price Index, 2009 Q3.

—Continued

Hospitals: Investing in Technology and Upgraded Facilities

Other significant outlays for hospitals involve IT. Every hospital is expected to meet new standards for having and using electronic medical records for its patients or face penalties in 2015.

Meeting that requirement safely will cost as much as $50 million for a midsize hospital.

—National Journal 2012

> Moody's lists "[i]ncreased need for capital relating to plant modernization and IT systems" as one of the top reasons for its negative outlook for hospitals in 2012.
>
> *—Moody's 2012*

Getting and making this new technology work for patients and meeting new and far-reaching government and private-sector requirements (coming from employers and payers) is a major investment for all hospitals. For cash-strapped hospitals it may be beyond their reach without merging with another hospital that can provide those funds.

These same hospitals may not be able to borrow to do so because of depreciation rules.

> "Independent hospitals tend to have narrower margins, meaning they can't simply fork over the cash … to digitize their records."
>
> *—National Journal 2012*

Doctors must meet similar requirements, yet regulatory barriers make that difficult or impossible to do so in collaboration with a hospital without being in its employ.

> "Investment in IT systems was indicated as the most important area of capital spending."
>
> *—Fitch Special Report 2012*

Hospitals: Essential Capital is in Short Supply

There is no doubt that limited access to capital for IT and other investments essential to providing high-quality care at lower costs is driving mergers.

> "The changing healthcare operating environment has led most hospitals to invest in an array of initiatives including IT, physician alignment, inpatient and outpatient facilities and expanding clinical access points in the community."
>
> *—Fitch Special Report 2012*

Capital markets for not-for-profit hospitals have still not fully recovered from the recent financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010. For many hospitals, particularly those with lower bond ratings, the best and perhaps only strategy to remaining viable in their community is merging with another hospital that has the financial resources it lacks.

> "Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."
>
> *—Moody's New Forces 2012*

The Michigan Attorney General recently approved a hospital deal citing access to capital as its primary benefit. The AG said that lack of capital made it impossible for the hospital to "perform necessary renovations, improvements, and expansion of its aging structures and equipment …." The deal, the AG said, "offers hope that the [community] will continue to be well served … for a long time to come."

Hospitals: Need to be Healthy to Provide the Most Value

> "Of all the transformations reshaping American healthcare, none is more profound than the shift toward value."
>
> *—Value through Partnership 2012*

Quality outcomes, affordability, and patient satisfaction are rapidly becoming the touchstones employers, payers, government and, most importantly, patients expect and demand. Meeting these challenges requires reshaping the hospital field, sometimes through mergers, alliances, partnerships or other innovative relationships.

This transformation will require time, patience and capital investment to build a continuum of care that accommodates 21st century technology and standards of medical care. When mergers are needed to help financially, geographically or otherwise challenged hospitals avoid "closure, bankruptcy, or payment default," or to become stronger and more efficient to meet current challenges and fulfill community needs, that should be a welcome development.

References available at *www.aha.org*, updated 12/12

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Questions for the Record from
Chairman Spencer Bachus
for the Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care"

September 19, 2013

Questions for Joseph Miller

1. While it may be too early to tell, do you think that there is any risk that certain consumers will be paying higher premiums as a result of the insurance exchanges implemented under the PPACA, and what would be the cause or causes of any such increase?

   A: Some consumers will likely pay higher premiums in the exchanges as a result of the ACA's requirement to purchase a richer benefit package than they were buying in previous years, additional ACA taxes such as the premium tax, and rating band compression. In addition, health plans will need to adjust for a potentially unbalanced risk pool in 2015 and beyond.

2. In your view, are there any additional factors that the antitrust enforcement agencies should take into consideration when reviewing a proposed health care industry transaction, or factors that should be weighed more heavily relative to other considerations?

   A: Consumer welfare is the touchstone of antitrust enforcement. As explained by Professors Richman and Greaney during the hearing, provider market power has resulted in significant consumer harm and warrants continued scrutiny by the agencies.

Questions for the Record from
Representative Doug Collins

3. Studies have shown that there are high barriers to entry into many health insurance markets, which enables health insurers to exercise significant market power over providers. As hospitals and other providers seek to align for a variety of reasons, is it possible that hospital realignment is the market balancing itself out? Do you think realignment may necessary in order to achieve a more value-based payment and delivery structure?

   A: Health plans have been in the forefront of the trend toward value-based payment systems and applaud efforts to reduce the unintended consequences of the fee-for-service system. This has occurred in spite of the challenging environment created by the large aggregation of market power by hospitals that has been well documented in numerous sources. Anticompetitive provider mergers lead to higher prices and other consumer harms and, as noted in the court's recent decision in *FTC v. St. Luke's Health System*, the move to value-based payments and quality improvement can be achieved in ways that don't involve this heavy cost. Thus consumers and antitrust enforcers don't need to accept the false choice of provider competition or quality improvement. Both are possible and health plans are committed to do their part in continuing the movement towards higher value, improved quality, and lower cost care for consumers.

Questions for the Record from
Chairman Spencer Bachus
for the Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care"

September 19, 2013

Questions for Barak Richman

1. In your view, were the healthcare markets consolidated in 2010 when the PPACA was signed into law?

Yes, by 2010, the vast majority – approximately 80% -- of Metropolitan Statistical Areas contained hospital markets that were deemed to be "highly concentrated," defined by having HHI indexes of greater than 2500. Merger activity continues, however, as hospitals continue to acquire other hospitals and physician practices and continue to expand their monopoly power.

In short, yes, healthcare markets were highly concentrated in 2010, but they continue to become more concentrated.

2. Since the PPACA may not offer competitive solutions to a consolidated marketplace, what are some pro-competitive policies that Congress should consider?

First, Congress should support the Federal Trade Commission and the Justice Department's Antitrust Division in their efforts to preserve and expand competition in health care markets. Some policymakers believe, for example, that PPACA has given CMS and other officials in HHS full authority to implement PPACA and especially, to promote the creation of Accountable Care Organizations (ACOs). PPACA, in my view, did not limit the FTC's role in formulating our national health care policy, and I hope Congress supports the FTC's efforts to intervene in and police the healthcare sector as it tries to adapt to a changing political and market environment.

Second, and relatedly, Congress should resist any temptations to offer antitrust immunities to healthcare providers. Some healthcare providers – specifically, hospitals in Georgia who attempted to merge, and dentists in North Carolina who have tried to exclude less costly competitors – have claimed that they are immune from the antitrust laws. Congress in the past has offered antitrust immunity to certain market actors, and it is possible that the healthcare sector might seek additional protection from Congress. I urge Congress to resist limiting – and perhaps to expand – antitrust scrutiny to the healthcare sector.

Third, Congress has the capacity to promote competition in assorted healthcare markets. For example, Congress could bring more scrutiny to—and perhaps prohibit—state Certificate of Needs (CON) laws. In addition, Congress could take measures to promote interstate competition among healthcare providers. Currently, state licensure laws and other administrative hurdles prevent providers from one state from competing with providers in another. Congress could revisit this body of locally-oriented and locally-controlled regulations that prevent meaningful competition from expanding across state lines and, perhaps, facilitating a national geographic market for healthcare services. Finally, Congress could take seriously the opportunities presented by telemedicine and create a regulatory framework more amenable to its potential. Rules on reimbursements, licensure, and other regulations prevent entrepreneurial providers from using cost-effective technologies to meet the needs of distant patients.

3. During the hearing, there was some consensus among the panelists regarding productive steps that could be taken to achieve a more competitive healthcare marketplace. In your view, in what areas do you believe there might be consensus to promote increased competition in the healthcare marketplace?

The ideas that received consensus at the committee hearing—from Mr. Balto, Mr. Tom Miller, Mr. Joe Miller, and Prof. Greaney—are embedded in work coauthored by myself and Clark Havighurst, in *The Provider-Monopoly Problem in Health Care*, Oregon Law Review, vol. 89 (2011). See http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1407163 The article's underlying idea is to use antitrust law to police provider monopolies. This idea has garnered additional attraction because our merger policies have failed to prevent the formation of provider monopolies, and thus we now need to prevent monopolies from inflicting undue economic harm on patients and insureds.

Three specific ideas are proffered in that article:

1. Continued Scrutiny over Provider Acquisitions, Including ACO Formation
   First, reflected in my answer to Question #2 above, the Federal Trade Commission and the Department of Justice's Antitrust Division should be dogged in scrutinizing current and future acquisitions and mergers within the health care sector, including proposed Accountable Care Organizations. This includes vertical acquisitions, such as when hospitals acquire physician practices or other outpatient services. These vertical acquisitions can secure a monopolist's dominance and enable it to extract supra-competitive prices in ancillary markets. The Federal Trade Commission, for example, deserves credit for recently blocking such an acquisition in Idaho (see FTC v. St. Lukes Health System, (District of Idaho, Case No. 1:13-cv-00116-BLW).

2. Requiring Unbundling of Monopolized Services
   Second, provider monopolists should be subject to anti-tying claims under the Sherman Act and the Clayton Act. We specifically propose that hospitals and other providers with market power should be required to unbundle, at a purchaser's request, their monopolized services from their services that are subject to market competition. This would allow health plans and self-insured companies to adopt purchasing policies that would encourage more price shopping among patients, encourage entry from providers who might bring competitive pressures on incumbent monopolists, and prevent monopolists from driving out competitors who remain in ancillary service markets.

3. Challenging Anticompetitive Terms in Insurer-Provider Contracts
   Third, provider monopolists should be prevented, under Section 2 of The Sherman Act, from including certain provisions in their contracts with insurers. These include
   - *Price-protection, payment parity, or "most-favored nation" (MFN) clauses.* These provisions deter insurers from sending patients to alternative, less costly providers because payors, under MFN clauses, are required to pay all providers the same amount.
   - *"Anti-Steering" Clauses.* These provisions prohibit insurers and other payors from directing their subscribers to alternative, less-costly providers. These provisions allow the monopolist to continue charging its inflated price and deters entry.
   - *Other exclusive payment arrangements.* Although "integration" between insurers and providers has been encouraged by some, chiefly as an effort to counteract fragmentation in the delivery system, many financial arrangements between insurers and providers do little more than secure each other's market dominance. The antitrust agencies should scrutinize intimate financial dealings between dominant providers and insurers, especially when those insurers also occupy dominant market positions.

This is not a comprehensive list of actions that Congress and the antitrust agencies can take, but it is the list of measures that received consensus at the committee hearing, from both Democratic and Republican witnesses.

4. Given the level of consolidation in the health care marketplace, and the legal and practical difficulties you point to in your testimony of reversing that consolidation, what role should the antitrust enforcement agencies play going forward?

Primarily, see my response to Question #3. The list of consensus items should give the agencies meaningful ammunition to address both detrimental acquisitions and detrimental conduct by provider monopolists.

5. Are there particular actions being taken by health care market participants that should be closely scrutinized by the antitrust enforcement agencies?

There should be continued antitrust scrutiny of provider acquisitions on all levels. Currently, within-market horizontal hospital acquisitions—that is, when one hospital acquires another nearby hospital—meet the highest antitrust scrutiny. These acquisitions cause the most obvious and most conventional kind of anticompetitive harm. However, most of America's local hospital markets are already highly concentrated, and thus there are few remaining opportunities for dominant providers to acquire additional hospitals within the same local market. Thus, even if these acquisitions meet the highest antitrust scrutiny, there are relatively few opportunities in which they can take place.

However, there remain two alternative kinds of acquisitions that, although they meet less antitrust scrutiny than within-market horizontal hospital mergers, can cause enormous anticompetitive harm and deserve the enforcement agencies' attention. The first is horizontal hospital acquisitions that involve separate geographic markets. For example, when Tenet Healthcare Corp. acquired Vanguard Health System (a $4.3 billion acquisition), the acquisition met little antitrust opposition because the two hospital chains competed in very few common local markets. However, such hospital chain mergers can have significant consequences on an emerging inter-regional marketplace. They also will give providers negotiation leverage over insurers that operate nationally, such that market dominance in one geographic market could be leveraged into additional monopoly profits in another. In short, horizontal mergers of large chains of hospitals deserve additional antitrust scrutiny even when such mergers do not impact local hospital markets though conventional mechanisms.

The second is vertical hospital acquisitions, such as when hospitals acquire physician practices. As I noted in response to Question #3, the FTC deserves praise for blocking such a vertical merger in Idaho (see FTC v. St. Lukes Health System, (District of Idaho, Case No. 1:13-cv-00116-BLW). The court, in granting the FTC's request for an injunction, expressed concern that the acquisition would create additional market power in outpatient services – in other words, the court was concerned about the horizontal elements of this acquisition. But significant economic harm can result from the vertical elements of such an acquisition. For example, a hospital monopolist can use a vertical acquisition to enshrine its monopoly position, especially if outpatient services can serve as a substitute for some inpatient services. Even for services that only hospitals can provide, such a vertical merger will prevent outpatient physicians from shopping among hospitals on behalf of their patients. In addition, a monopolist hospital can use its network of outpatient services to serve as a funnel for increased inpatient admissions, thus undermining any potential benefits of coordination and integration.

In sum, conventional policy suggests that mergers should be challenged whenever there are horizontal acquisitions within a common geographic market. As applied to health sector acquisitions, this has meant that mergers of nearby hospitals receive antitrust scrutiny from the enforcement agencies. But given the dynamics of hospital-insurer negotiations and reimbursement policies, our enforcement agencies should also heavily scrutinize acquisitions among hospital that operate in different geographic markets and acquisitions outpatient services by hospitals.

Questions for the Record from
Chairman Spencer Bachus
for the Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care"

September 19, 2013

Questions for Thomas Miller

1. While there was some consolidation in the health care industry that pre-dates the PPACA, do you think the prospect of the new health care law and its enactment caused industry participants to consolidate further?

   The trend toward further consolidation has continued, but, at least initially, it has generally changed more in terms of consolidation across various health sectors than within any single sector. There is not one single, simple consolidation trend throughout all sectors of the health care industry. The increase in vertical consolidation has been greatest in the magnitude of physician practices that continue to be acquired and consolidated within hospital-based contractual arrangements. Hospital sector consolidation per se has not increased much above its peak that took place primarily during the previous pre-PPACA decade. Insurer consolidation within the individual market segment is likely to increase – not in the first year of full PPACA exchange implementation – but over the next few years, as smaller "outside market" insurers either exit or are acquired by larger insurers and recent start-up insurers competing in the new exchanges fail to reach critical mass or achieve a sustainable place within that newly evolving market.

   Over time, the ACA's heavy regulatory burdens, complexities, and other barriers to new entry will tend to entrench a handful of larger insurers who are best at coping with them. Early experience in most of the new exchange markets for individual coverage already indicate that the previous dominant insurer retains the same or larger market share (with a few exceptions).

2. Since the PPACA may not offer competitive solutions to a consolidated marketplace, what are some pro-competitive policies that Congress should consider?

   The most important pro-competitive policy would involve reversing the primary direction of PPACA policies, which tend to insist on greater standardization driven by political goals (centralized regulation, income redistribution, off-budget spending through mandates), rather than pro-competitive choices made by patients and other private payers facing more transparent market-based prices. Deregulating the insurance choices available to consumers in the new health exchanges is a necessary first step. Within the realm of health competition policy per se, better solutions to marketplace consolidation that pre-dates the PPACA as well as the further consolidation triggered by it include: Curbing abuses of State action immunity, challenging anticompetitive terms in insurance provider contracts, requiring unbundling of monopolized health care services, promoting

inter-regional competition in health care services, removing or limiting regulatory barriers to entry by new health sector competitors, and empowering consumers and private purchasers with better access to information tools and resources.

3. Is there a risk that, due to the standardizing provisions of the PPACA, the insurance market will shift to a commodity-based marketplace, and, as a result, we might see an incentive for further consolidation to achieve economies of scale?

   Yes, that is both a serious risk and an unfortunately all-too-clear goal of the PPACA, which aims to shift insurers' competition to the basic premiums they charge for packages of insurance benefits that differ only in their relative proportions of cost sharing. In such a commoditized market framed by essential benefits packages, minimum loss ratios, adjusted community rating, guaranteed issue, and individual purchase mandates, the most "successful" insurers are likely to be those that can keep their administrative expenses lower than other competitors. That is a recipe for a business emphasis on chasing after real and imagined economies of scale, rather than fundamentally serving the different preferences and needs of various types of consumers and purchasers more effectively with more differentiated and targeted products.

4. You state that ACOs may give rise to certain antitrust and competitive concerns. Why do you believe that to be the case?

   Although the ACO regulations, rules, and practices are likely to continue to evolve further over time (in order to find better configurations that start to work!), their initial bias has remained toward encouraging hospital-centric configurations that are likely to increase opportunities for horizontal AND vertical consolidation, and augment market power, in the health care sector. The initial ACO structures remain relatively opaque and resistant to ex ante patient choice. To reach their baseline-cost-reduction targets, they are biased to reward size and scale much more than any promised, but thus far elusive or non-scalable innovative efficiencies in care delivery. The ACOs also provide strong temptations for larger consolidated entities to increase their market power while shifting costs across the Medicare and below-65 private-market segments.

5. Do you think that the enactment of the PPACA has raised barriers to entry in either the hospital or insurance market?

   The PPACA has raised barriers to entry primarily by increasing the upfront "entry" fee to comply with its mounting burden of regulation. Compliance costs essentially raise the capital requirements for start-ups and smaller competitors, disproportionate to their likely revenue. Larger incumbent organizations have a "comparative" advantage in spreading those costs across a broader base, having access to more in-house administrative personnel, and utilizing a wider network of political and lobbying resources.

Response of Professor Thomas L. Greaney

Questions for the Record from Ranking Member Steve Cohen

Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition"

House of Representatives Committee on the Judiciary

Below are my responses to the questions posed in connection with my testimony before the Subcommittee on Regulatory Reform, Commercial and Antitrust Law on September 19, 2013

1. I view the growth of ACOs as a potentially important pro-competitive force in health care. The reforms encouraging development of ACOs, patient-centered medical homes, and other integrated delivery systems enacted under the Affordable Care Act (ACA) serve to encourage fragmented providers to coordinate their services and compete *more* effectively. To the extent that some consolidations go beyond pro-competitive integration and create monopolies or oligopolies, the problem is one that exists throughout the economy: some firms are willing to "test the envelope" and try to acquire market power. It is therefore misleading to attribute causation to the ACO concept.
2. Again, the fact that some hospitals and specialty physician practices have undertaken or attempted to undertake anticompetitive mergers *in response to* the ACA, should not in any way be deemed to be a *fault* of the ACA or its design. Indeed as I stated in my testimony, such mergers are an effort to thwart the pro-competitive objectives of the law and the market-based health care system that every administration has supported for the last thirty years.
3. Mr. Miller's statement overlooks the fact that integration is critical to achieve the benefits of better quality and more vigorous competition. Entities such as ACOs, HMOs and provider networks will only be incentivized to improve care at affordable prices if they co-ordinate their practices, share information, and produce data that evidences better outcomes. That way "consumers" (employers, payers, and patients) can evaluate performance and compare alternatives. Thus it seems to me that the statement creates a false dichotomy.
4. It is a textbook economic principle that standardization of products or services will improve competitive outcomes where consumers face complex offerings with multiple features that make it impossible to compare one with another. That phenomenon is certainly the case with respect to health insurance offerings. Extraordinary variations in the amount and methods for calculating co-pays, deductibles, annual and lifetime limits, benefits, and exclusions make price comparisons impossibly difficult for even the most sophisticated buyer, including most employers. A large literature describing the inadequacies of the individual insurance market that existed before passage of the ACA confirms these observations. Thus standardization is an essential part of competitive reform. Finally, there is no necessary correlation between some standardization and consolidation. With product standardization, insurers face greater incentives to compete on the

quality and outcomes of their provider networks as well as their own customer services such as appeals processes—things consumers really care about.

5. I find it hard to understand how the ACA can be faulted from a competition-oriented perspective for the myriad efforts it undertakes to fix our broken and inefficient reimbursement system. One would be hard pressed to find a health policy expert or economist who would challenge the wisdom of the ACA's movement toward bundled payments, value based purchasing, and global payments to integrated provider units like ACOs and patient centered medical homes. Obviously, new regulations are required to change payment arrangements but generalized complaints about "regulatory burdens" ignore the fact that a system that moves away from fee for service payment and eliminates payers' incentives to pursue good risks by medical underwriting substantially *reduces* costs and paperwork throughout the system.
6. I could not disagree more. A theme that I have stressed throughout my academic career and in many of the publications listed on my c.v. is that market imperfections drive the inefficiencies and high costs of our system. Mr. Miller's statement might have validity if he concedes that some government regulations (encouraged and promoted by health industry players) reinforce those market imperfections.
7. I completely agree that the state action immunity doctrine needs to be narrowed in that, as construed in some cases, it permits anti-competitive collusion. Recent decisions including the Supreme Court's opinion in the Phoebe Putney case last year and the Fourth Circuit's decision in North Carolina Board of Dental Examiners v. FTC illustrate that there is a growing consensus that the doctrine's application should be limited.
8. I would urge first that Congress assure that the federal antitrust enforcement agencies, the Antitrust Division of the Department of Justice and the Federal Trade Commission, receive both adequate funding and effective oversight so as to assure vigorous enforcement of the law in the health care industry. Because most health care issues involve local markets, it also would be extremely helpful if Congress could develop a mechanism to help state Attorneys General fund their oversight of state and federal antitrust law, as well as the development of pro-competitive policies by their state insurance regulators and health exchanges. Finally, I would urge Congress to mandate sharing of information between CMS and the antitrust enforcement agencies. Disclosures should include detailed data regarding quality and cost performance of providers and ACOs and other networks serving beneficiaries of Medicare, Medicaid and other federal programs. In addition, I would recommend legislation enabling CMS to require pre-authorization by the antitrust agencies for renewals of certification of participation in programs such as the Medicare Shared Savings Program based on the agencies' assessment of market power issues.

Questions for the Record from
Congressman Doug Collins
for the Hearing on "The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care"

September 19, 2013

Questions for David Balto

1. Independent and community pharmacies play a vital role in Northeast Georgia and across the nation. And they are being crippled by burdensome regulations and unfair and often abusive PBM practices.

   Yet in recent years, the FTC has not brought any enforcement actions against PBMs for anticompetitive, deceptive, or egregious conduct, and when states have attempted to regulate to product consumers from these practices, the FTC has consistently sided with the PBMs. Given the lack of FTC involvement and enforcement in PBM mergers, and the FTCs general opposition to any state regulation of PBMs, they seem to enjoy a de facto antitrust exemption.

   My constituents are very concerned, as am I, that the way PPACA treats PBMs will further harm independent and community pharmacies and further restrict consumer choice in the healthcare industry.

   What steps, if any, Congress should take to ensure that independent pharmacies and PBMs are able to compete on a level playing field in the post-PPACA healthcare market?

2. In recent years, the FTC has engaged in several regulatory and judicial actions to prevent anti-competitive provider consolidation, including a U.S. Supreme Court case that sided with the FTC on a hospital merger in my home state of Georgia. What are some ways that Congress could better equip the FTC with the tools necessary to examine mergers and acquisitions that may be anticompetitive and anticonsumer?

Questions for the Record from
Ranking Member Steve Cohen

3. Some have suggested that the ACA has prompted a recent wave of mergers among hospitals and other providers. What is your response?

Tom Miller says that efforts to better integrate and coordinate health care delivery "risks coming into conflict with pro-competition policies favoring greater price transparency, improved quality reporting, and lower prices." How do you respond?

4. Regarding the Health Insurance Marketplaces set up under the ACA, Tom Miller says that they are structured to gravitate towards more standardized insurance plans, which

ultimately will encourage greater consolidation and less competition in health insurance markets. How do you respond?

5. Tom Miller suggests that the ACA's "reimbursement schemes and regulatory burdens are more likely to entrench large, existing players in health care markets than to encourage start-up innovators." How do you respond?

6. What do you think of Tom Miller's suggestion that the state action immunity doctrine "needs to be tightened?"

7. What can Congress do to strengthen antitrust enforcement in health care?

8. How can the FTC strengthen its health care antitrust enforcement?

9. There is some concern about potential concentration in the pharmacy benefit manager market. What should the FTC do about problems in the PBM market?

10. One expert report examining group purchasing organizations (GPO's) - organizations that contract to buy medical equipment and supplies for hospitals, but are paid by the hospital suppliers and medical device manufacturers - suggested that GPOs cause hospitals, and ultimately payers such as individuals, the government and insurers, to overpay for medical devices. The report concluded that approximately $25 billion in private healthcare expenditures, and $ 11.5 billion in federal health care spending, could be saved annually if GPOs were paid by hospitals instead of suppliers. Do you think the fact that GPOs are paid by suppliers creates a conflict of interest for GPOs? Do you agree there could be savings to payers and the health care system if the payment structure were changed?

Answers by David Balto

1. This question is tremendously appropriate because of the lack of sound enforcement against PBM over the past several years. As you've noted the lack of FTC enforcement effectively gives the PBMs a de facto antitrust exemption. In addition PBMs are the least regulated segment of the healthcare market.

There are a number of steps Congress can take to help insure independent pharmacies can compete on a level playing field. First Congress should enact an antitrust exemption so that pharmacies can collectively negotiate with PBMs. H.R. 1188, Preserving Our Hometown Independent Pharmacies Act of 2013, would provide a limited exemption for community pharmacies allowing them to band together to negotiate better contractual terms from PBMs. I have testified in the past that bills such as H.R. 1188 would both improve patient access and the level of services received by patients. Too often PBMs are able to coerce patients into very narrow selective networks.

Second, Congress should continue with oversight function and carefully monitor the FTC's lack of antitrust enforcement in the PBM market. The FTC made a serious error when it

failed to challenge the Express Scripts/Medco merger. The FTC can go back and review mergers that have been approved in the past and the Congress shouldn't encourage the FTC to review the Express Scripts/Medco merger.

Third, Congress should encourage the CMS to reform the practice of preferred networks under Part D. CMS has proposed reforms to these two provisions in Part D and Congress should encourage CMS to adopt the proposed regulations.

2. The FTC has appropriately and carefully examined mergers and acquisitions in the healthcare industry. One unfortunate gap however, is its jurisdiction over health insurers. Congress could help strengthen healthcare enforcement generally by eliminating the antitrust exemptions for health insurers under the McCarran-Ferguson Act. As noted in my testimony the FTC seems to believe that the McCarran-Ferguson Act prevents it from bringing enforcement action against health insurers. That's an unfortunate gap in the law and Congress should eliminate that gap by repealing the antitrust exemption for health insurers.

3. There is little evidence that the ACA has prompted the recent wave of mergers among hospitals and other providers. There are many reasons for hospital and provider consolidation including achieving economies of scale, better coordination of services and providing a more integrated approach. Much of the learning that led to the enactment of the ACA suggested that healthcare was being inefficiently provided because of the lack of coordination between hospitals and providers to the extent that this type of consolidation improves that type of integration that certainly can be a benefit and help lower overall healthcare costs.

Mr. Miller's suggestion that coordinated healthcare delivery could be in conflict with pro-competition policies is simply mistaken. Integration and coordination are not inconsistent with greater price transparency, improved quality reporting and lower prices. Indeed, effective integration and coordination can lead to each of these pro-competitive results.

4. Mr. Miller is incorrect that the way Health Insurance Market Places are set up would lead to standardized insurance plans. Under the ACA, products offered to consumers in the Health Insurance Market Place must guarantee a minimum level of benefits. This "standardized" benefits package insures that consumers will all receive an appropriate level of benefits. Competition in the Health Insurance Market Place occurs when consumers choose from one of four levels of plans--bronze, silver, gold, or platinum. Each level has a different cost-sharing mechanism in the form of premiums and deductibles. Insurance companies provide plans across numerous levels competing for consumers by offering different products and benefits above and beyond the minimum requirements. Much like other aggregate sales websites, the Health Insurance Market Places provide greater information to consumers who will be able to readily compare different insurance options. With "standardized" baseline benefits established by the law, insurance companies will have to compete via cost, innovations, and enhanced benefits leading to increased competition and quality.

5. There is little evidence that the ACA's reimbursement schemes and regulatory burdens will entrench large existing players in healthcare markets. Many of the reforms in the

ACA actually will help smaller firms enter the market and compete more effectively. In fact, as cited in my testimony, the ACA's introduction of new payment schemes such as ACOs, bundled payment, and patient centered medical homes will likely encourage competition and offer new opportunities to rural and specialty healthcare providers.

6. I strongly disagree with Mr. Miller's suggestion that the state action immunity doctrine needs to be tightened. Indeed the antitrust agencies have been very aggressive in pursuing cases under the state challenging matters under the state action immunity doctrine. I think sometimes that type of enforcement can be misguided because regulatory actions may lead to better allocation of services and improved healthcare. The antitrust agencies should be differential when states act to try to preserve access to healthcare.

7. As I suggested before Congress should repeal the McCarran-Ferguson Act by eliminating the antitrust exemption for health insurers. That alone will lead to greater competition in health insurance markets and help improve the delivery of healthcare.

8. As I suggested in my testimony the FTC should look at its broad range of powers especially its ability to challenge unfair trade practices under Section 5 of the FTC Act.

9. As I suggested in my response to Question 1 the FTC should be more aggressive at attacking potential concentration in the PBM market. In addition the FTC should conduct a retrospective review of the Express Scripts/Medco merger to determine the anticompetitive effects from the merger.

10. I think the expert report carefully examines the impact of GPOs on the delivery of medical equipment and supplies. Based on its study it carefully notes the increased costs that have come about because of a conflict of interest. I believe Congress should more carefully examine the role of GPOs and the degree that GPOs create a conflict of interest. What could be especially important is eliminating the safe harbor for kickbacks from manufacturers to GPOs. It would appear that there would clearly be substantial savings to payers and consumers if the payment structure was changed.

I again thank you for allowing me to speak on these important matters, and I hope I have answered your questions. If you need further clarification, please do not hesitate to contact me.

Sincerely,

David Balto

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