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

"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

December 1, 2010

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Chairman Conyers, Ranking Member Smith, and other members of the committee, I appreciate the opportunity to come before you today and testify about antitrust enforcement in the health care industry. As a former antitrust enforcement official I strongly believe the mission of the Federal Trade Commission and Antitrust Division of the Department of Justice is vital to protecting consumers and competition. However, the paradigm of health care antitrust enforcement needs to be revised in order for enforcement to fully support the objectives of health care reform. This nation's year-long debate on health care reform illuminated many faults and weaknesses in our health care system, while highlighting the potential for meaningful reform to improve health care results and better control costs. It is time for antitrust enforcers to fully embrace the results of that inquiry and realign priorities in order for antitrust enforcement to become a tool and not an obstacle to improving our health care system.

Today's hearing on antitrust enforcement in the health care industry could not be more vital. The nation is taking the first critical steps toward implementing reform and making sure health care markets are competitive. That is why at the Center for American Progress we held a program on health care competition this summer that brought together key regulators from the Office of Consumer Information and Insurance Oversight, OCIIO, the Antitrust Division, a State Insurance Commissioner and a prominent health insurer. The program highlighted many of the obstacles to effective competition in health insurance markets, and how regulators and antitrust enforcers can work together to make the market work. We plan similar programs on health insurance competition and consumer protection in the near future.

What are the important lessons from the health care reform debate that both regulators and antitrust enforcers need to embrace?

- Health insurance markets are broken—almost all markets are highly concentrated with resulting supracompetitive profits, escalating numbers of uninsured, an epidemic of deceptive and fraudulent conduct, and rapidly escalating costs. The Congressional debate clearly and unequivocally established the need for the comprehensive reform that was enacted. Countless Congressional hearings uncovered a disturbing pattern of egregious, deceptive, fraudulent, and anticompetitive conduct in health insurance markets.
- Integration is not the problem in health care, but is an important solution for improving quality and cost in the fee-for-service health care system. Much of the health care debate focused on the lack of coordination among health care providers and how this led to

excessive costs and poor health care results. The purpose of the accountable care organizations, ACOs, is to provide entities that can better coordinate care and be held accountable for overall health care results.[2]

- If there is a competitive problem in health care markets it is due to aggregations of market power, such as in health insurance, and not because of improper integration among health care providers.

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

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

In fact, consumers and public welfare as a whole may be better off if providers can band together to have some level of countervailing power to deal with powerful insurers. Former Congressman Tom Campbell (R-CA) in a series of thoughtful law review articles has demonstrated that permitting sellers of services or goods to merge may improve welfare when dealing with powerful buyers.[3]

More concretely, countervailing power for providers may benefit consumers. Health care providers are often the most effective advocates for patients when insurance companies cross the line and engage in abusive and deceptive conduct. Health care providers can use their negotiating power to prevent insurers from implementing "physician gag" clauses which prevent physicians from informing consumers about insurance options. Health care providers can use their power to challenge deceptive conduct that harms both consumers and providers. Take the Ingenix case as an example—where United Health care's subsidiary deflated usual and customary rates harming millions of consumers.[4] It was associations of doctors including the AMA that led the charge in exposing these practices, leading to a landmark remedy and over $350 million in damages to date.

What about the idea that the insurer or the PBM is the consumer? Insurers and PBMs do attempt to control costs for employers and other purchasers of health plans. While these entities

may attempt to control cost they are also for-profit entities with an overriding incentive to maximize profits. When there are battles between health care providers and insurers, the agencies almost always weigh in on the side of the insurers. But insurers are not the consumers. The endless list of competition and consumer protection cases against insurers and PBMs show that health insurers and PBMs frequently act to harm consumers. The primary goal of these for-profit insurers and PBMs is to serve their shareholders and their profit margins, and not consumers. They are not the representatives of consumer interest.

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

> [E]ven if it were true that paying West Penn depressed rates enabled Highmark to offer lower premiums, it is far from clear that this would have benefitted consumers, because the premium reductions would have been achieved only by taking action that tends to diminish the quality and availability of hospital services. *See Brown*, 50 F.3d at 1061 (Wald, J., dissenting); Warren S. Grimes, *The Sherman Act's Unintended Bias Against Lilliputians*, 69 Antitrust L.J. 195, 210 (2001) ("The very nature of monopsony or oligopsony power is that it tends to suppress output and reduce quality or choice.").[5]

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

It is time for our antitrust enforcers to recognize the lessons from health care reform and adapt the antitrust paradigm. As I discuss in more detail below, the history of the past decade is characterized by largely misplaced enforcement priorities. Although health insurance markets are plagued by anticompetitive and abusive conduct, there were no competition or consumer protection enforcement actions against health insurers in the last administration. At the same time almost all of the FTC health care enforcement actions were against efforts by physicians to collectively negotiate. Physician collaboration has been living as a suspect class and represents the only area where antitrust agencies apply the "per se" label and condemn endeavors without analysis of anticompetitive effects. (The "per se" rule is the legal guillotine of the antitrust laws. Under the per se rule, the government need not demonstrate the conduct has harmed competition or consumers.) The FTC brought 31 cases, all settled, probably because of the high cost of a government investigation. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did consumers file any antitrust suits seeking damages for the alleged illegal conduct. (There was only one case filed by an insurer and it lost.)[6] This disproportionate focus on physician groups was supported by no evidence that higher physician costs were a significant force in escalating health care expenditures.

In addition to these unbalanced priorities, the FTC has demonstrated a disproportionate and unreasonable skepticism for collaboration by physicians. There is an approval process for these ventures; about 25 were approved in the last four years of the Clinton administration and only five were approved in the Bush administration. The process for approval has become remarkably complex, time consuming and expensive. Even though the agencies are committed to providing advice in 90-120 days, in the past decade the approval process has averaged over 436 days, or just slightly less time than it took Congress to debate and enact reform of the entire health care system.

Here are the essential points of my testimony:

- The central priority in antitrust enforcement should focus on health insurance. From both a competition and consumer protection perspective health insurance markets are severely dysfunctional. Few markets are as concentrated, opaque, and a fertile ground for deceptive and anticompetitive conduct. Preventing any increase in concentration or any anticompetitive practices by insurers should be the central priority of the antitrust enforcers.
- Health care enforcement priorities need to be realigned in the wake of the reform efforts and the new challenges that will arise from reform. The past focus on physician negotiations is simply misplaced. Enforcement in these cases should focus on situations with demonstrable competitive harm.
- The FTC and DOJ Health care guidelines which were last issued in 1996 need to be revised to provide greater opportunities for collaboration among providers. The guidelines have been interpreted in a fashion that puts the thumb on the scale in favor of insurers and against providers. There should be clearer safe harbors especially when provider groups are nonexclusive. In addition, specific safe harbors should be provided for pharmacies seeking to collaborate with ACOs.
- The agencies must establish meaningful deadlines for issuing advice on collaborations and stick to those deadlines.
- The agencies should focus much more on the concern of market power among providers. Other than hospital mergers, neither the FTC nor the DOJ have brought a case challenging provider market power since 1994, and this should be an area of reinvigorated attention.

I. Focusing enforcement on rampant competitive and consumer protection problems in health insurance

Let me begin with the first key observation for this nation's careful scrutiny of health care—the lack of competition and effective transparency in health insurance markets. I will not detail the mountain of evidence of how these markets do not function effectively; this Congress recognized these markets lacked sufficient competition and transparency.[7] Beginning to repair these markets is a core element to the Patient Protection and Affordability Care Act.

Why are choice and transparency important? It should seem obvious. 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 two elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: a recent report by Health Care for America Now found that in 39 states two firms control at least 50 percent of the market and in nine states a single firm controls at least 75 percent of the market.[8] A 2009 AMA study found almost 99 percent of all markets are highly concentrated.[9] 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.

What is the result of this poorly functioning market? The number of uninsured has skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn't really protect them. In the past six years alone, health insurance premiums have increased by more than 87 percent, rising four times faster than the average American's wages. Health care 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.

II. Realigning health care enforcement priorities

If one fact is clear from over a year of health care debate, it is that health insurance markets are broken. Members of Congress heard testimony from dozens of individuals who described how they were harmed by egregious, deceptive, and anticompetitive conduct by dominant health insurance companies. Congress also heard from scores of employers who testified that they were unable to provide basic health insurance for the employees because of escalating premiums and other forms of anticompetitive conduct. Congress appropriately enacted significant reforms that hopefully will begin to restore greater protections for consumers.

Unfortunately, the antitrust agencies are not as well-positioned as they should be to fully assist the new federal regulators in beginning to reign in health insurers. In the prior administration, there were no enforcement actions against anticompetitive or deceptive practices by health insurers. None. Instead, the antitrust enforcement resources were almost entirely dedicated to challenging physician negotiating arrangements. In addition, the administration permitted a tremendous number of health insurance mergers to occur with relatively few challenges. As noted above, the result has been the creation of a market with substantial competition and consumer protection problems.

The problem of misdirected priorities is unfortunate. The agencies pride themselves on setting priorities that bring the greatest benefit to consumers. In the past administration, all except one of the health care competition cases—over 30 cases—were brought against doctors for alleged price fixing. Did the consumer benefit from these enforcement actions? Only one enforcement action resulted in a private antitrust suit seeking damages—and the insurance company plaintiff lost. Over 40 percent were in rural markets that suffer from chronic shortages of providers. Almost all the cases were settled since provider groups can rarely afford a battle of a protracted antitrust suit. The settlements rarely allege consumers had to pay more; rather to the extent they allege harm, it is that the physicians sought higher reimbursement from insurers. The fact that a powerful insurer may not be able to secure lower reimbursement from physicians does not mean consumers suffer; rather, any lower reimbursement may have simply ended up in higher profits for insurers or reductions in reimbursement may have led to worse health care, as the Third Circuit observed in the *Highmark* case.

Are these physician negotiation groups a significant competitive problem? Congress exhaustively examined problems in health care markets for over a year. There was no mention of these alleged physician negotiation groups. Nor does the academic literature on rising health care costs identify these entities as a significant cause of rising health care expenditures. The results of the Congressional health care examination are clear—the problem is in a lack of competition and deceptive conduct in health insurance markets and that is where the agencies' resources must be focused.

Recently, the DOJ has started to set a better balance in enforcement priorities and pay some much-needed attention, at least, to broken health insurance markets. At a recent meeting of the American Bar Association, Assistant Attorney General Christine Varney described the results of a study they conducted on barriers to entry in health insurance markets in which the DOJ found that these barriers are indeed significant, and as a result, the antitrust enforcers must take action to protect existing competition and choice in health insurance markets. The DOJ threatened to challenge the merger of two Michigan health insurers, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan this past March. The merger would have created an insurance behemoth with about 90 percent of the market in Lansing. Importantly, the DOJ recognized not only harm to employers which need to purchase insurance, but also physicians who would be threatened by reduced reimbursement. Because of the DOJ's threat, the companies called off their merger, maintaining some level of competition in that market.

Moreover, in mid-October of this year, the DOJ filed suit against Blue Cross Blue Shield of Michigan for most favored nations, MFN, provisions that escalated prices and increased entry barriers in the commercial insurance market.[10] The suit alleges that MFN clauses effectively made Blue Cross immune from competition by guaranteeing that no other health insurer could secure a better rate from a contracted hospital. According to the complaint, Blue Cross has 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 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 most favored nations provisions.

Both of the recent DOJ enforcement actions suggest a better use of enforcement resources and setting of priorities. Each of these matters may have a far more salutatory impact on competition than the physician matters in the prior administration. I suggest three additional changes to improve overall health care enforcement:

- The DOJ and FTC should reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should use its full powers under Section 5 of the FTC Act to prosecute anticompetitive conduct that may not violate the Sherman or Clayton Acts.
- The FTC and DOJ should establish much stronger standards for health insurance merger enforcement under their merger guidelines. The FTC should conduct a retrospective study of health insurer mergers to identify those which have harmed consumers.
- Require evidence of actual competitive harm in enforcement actions against provider groups. All of the actions brought by the FTC against provider groups in the last decade were brought under a per se rule of illegality (or truncated rule of reason analysis) that did not require the FTC to demonstrate any anticompetitive effects. This approach has created an unnecessary and harmful barrier to provider collaboration. Certainly there may be instances where provider groups may have acted anticompetitively in attempting to fix prices; however, the antitrust agencies should use their prosecutorial discretion and only attack those endeavors that actually have an adverse impact on consumers and evidence of competitive harm.

III. Setting standards for guidance that are a bridge too far

Besides misdirected enforcement priorities, the enforcement agencies have taken an extremely limited approach to permitting collaboration by health care providers. The most recent statement of guidance on permissible collaboration is the agencies' joint Statements of Antitrust Enforcement Policy in health care (guidelines), last revised in 1996, over fourteen years ago. Obviously the health care market has changed dramatically during this period. Moreover, under these guidelines, the agencies have taken an extremely limited approach to permissible collaboration by health care providers. For instance:

- During the Bush administration, they approved only four provider collaboration groups, compared to over 25 in the Clinton administration.
- The costs of securing a business review letter to permit collaboration have grown exponentially. The cost of securing a business review letter now exceeds well over $100,000, which is clearly out of reach for any group except a very large group of providers, and the process can take over a year to obtain a letter.
- Because of the elaborate standards necessary to satisfy the enforcement agencies, these groups must increasingly involve large numbers of physicians. Most of the approved entities involve well over 100 physicians. Ironically, the standards applied by the agencies are effectively forcing physicians to form groups that are so large that they may appear to acquire market power; precisely the problem the antitrust laws want to avoid.

- Even when these groups can overcome the severe and costly gauntlet required to get necessary approval, insurance companies often refuse to deal with these groups.

Let's just address the issue of timing. There is a process for providers to seek advice from the FTC or DOJ on potential alliances or other forms of collaboration. In the 1996 guidelines the agencies committed to answering requests within 90 days for providing advice to provider groups and 120 days for physician hospital collaborations. During the first four years under the guidelines approximately 30 letters were issued and the timing commitments were usually met.

In the past 10 years the process has become much more time consuming and expensive. Only five requests were approved. I spoke with the attorneys representing the six proposed ventures and they each described an exhaustive and expensive process. Each of the letters cost over $100,000 in legal fees. The time for approval was between 263-645 days:

Matter	Year	Time for approval
Medsouth, Inc.	2002	236 days
Bay Area Preferred Physicians	2003	340 days
Suburban Health Organization	2006	573 days
Medsouth, Inc.	2007	348 days
Greater Rochester IPA, Inc.	2007	447 days
Tristate Health Partners, Inc.	2009	645 days

The average time was 436 days. This is a much more time consuming and expensive process than that for securing an advice letter in areas outside of health care.

Even after these ventures are approved insurance companies often refuse to deal with them. There is a simple fact that is becoming increasingly clear. Insurance companies are often not interested in the efforts of health care providers to improve health care quality. Instead, they simply want to secure the services of health care providers at the lowest possible cost. The ultimate result is that health care providers are forced to do more with less and consumers suffer the results of assembly line health care.

The standards applied by the antitrust agencies and the guidelines need to be revised. Sens. Herb Kohl (D-WI), Patrick Leahy (D-VT), Dianne Feinstein (D-CA), Sheldon Whitehouse (D-RI), and Arlen Specter (D-PA) recognized the need to revise the health care guidelines in a letter to AAG Christine Varney and Chairman Jon Leibowitz last year. They wrote:

> The *Statements* are now 15 years old and while their success in providing clear and concise guidance is a testimonial to both antitrust agencies and an excellent model of agency collaboration, an updated version including a broad and clear statement of enforcement policy is needed. Similar to the early 1990s when the agencies issued the Statements, we are in another time of 'fundamental and far-reaching change' in the health care field. Clear and user-friendly guidance would reduce barriers to coordination and innovation ultimately leading to cost efficiencies in the health care delivery system.[11]

The challenge of allowing providers to collaborate under the existing health care guidelines is significant. We should be clear about the cost of an overly narrow approach to permitting health care collaboration. Doctors are prevented from providing a full range of services to improve health care quality and lead to better health care results. Ultimately, consumers suffer when physician reimbursement is reduced and consumers are relegated to assembly line health care.

This issue is particularly critical because an essential part of health care reform is the formation of accountable care organizations; systems which provide incentives for the various providers delivering a patient's care to cut costs by coordinating care, focusing on prevention, or otherwise improving quality of care. ACOs can arguably raise some of the same concerns of permissible integration under the health care guidelines. Conceivably, the agencies may impose very strict requirements, or may see physician cartels lurking behind these arrangements. As the AMA has observed "the current clinical integration standards published in the Statements and the FTC advisory opinions to date will deter the formation of ACOs. If the FTC/DOJ standards remain unaltered, the ACA's important invitation to physicians to form ACOs will be reduced to a mere gesture."[12]

Indeed, at a recent ABA conference, representatives of both the FTC and DOJ cautioned that ACO-like collaboration would only be permissible for CMS-sanctioned programs, leaving open the significant risk that the same ACO-like collaboration would be deemed illegal if applied to commercial insurance contracting. This approach would make it difficult for ACOs to be formed. Ironically, with respect to those ACOs that are formed, the agencies' approach might permit for-profit commercial insurers to free ride on the benefits derived through clinical integration. It should be a top priority of the enforcement agencies to promptly provide guidance to permit the significant formation of ACOs.

There is a recent, hopefully positive sign that the antitrust enforcers are beginning to recognize the need to take a new approach to physician collaboration. On October 5, 2010, the FTC, HHS Office of Inspector General, and the Centers for Medicare & Medicaid Services held a joint workshop to discuss the antitrust challenges facing the formation of ACOs. At this event, FTC Chairman Jon Leibowitz stated, "We want to explore whether we can develop safe harbors so doctors, hospitals, and other medical professionals know when they can collaborate and when they cannot." Leibowitz also remarked, "We are also considering whether we can put in place an expedited review process for those ACOs that fall outside of the safe harbors."[13] These statements offer hope for changes in antitrust enforcement and the creation of a market where health care providers can effectively collaborate to create ACOs and deliver less costly and higher quality care.

We hope that the agencies deliver on this promise with a significant revision of the guidelines. Workshops alone are not sufficient—earlier workshops in 2003 and 2008 did not lead to any revision of the guidelines; hopefully this time will be different.

Recommendations:

- The agencies should revise the guidelines and provide a greater range of safe harbors to permit a broader range of collaboration by providers.

- The agencies should make a greater effort to meet their commitments to issue advice letters in a timely fashion.

IV. The need for a safe harbor for pharmacies to participate in ACO networks

The health care reform legislation envisions a much broader form of collaboration to improve health care and control costs. Pharmacists can play a critical role in these efforts, since they often have the greatest contact with patients and are far more accessible than hospitals or physicians, especially in underserved inner-city or rural markets. Community pharmacies provide personal service that is preferred by consumers and often helps patients attain better health outcomes. In a community pharmacy setting, patients and pharmacists typically establish face-to-face personal relationships over an extended period of time. Community pharmacists often have a strong relationship with patients and, as a result, are more aware of their health status, can recognize any changes, and identify topics to address with physicians.

Pharmacists are a critical link in effective health care management. As a result of face-to-face service and personal relationships, pharmacists can help patients manage lifestyle choices, and monitor and improve drug adherence. For example, a recent *Los Angeles Times* article detailed how pharmacist Steven Chen advised his 55-year old diabetic patient about good nutrition, physical activity, and the importance of taking his medications regularly. As a result, Chen helped his patient lose weight, stabilize his condition, and improve his long-term health care costs. Frequent interaction between independent pharmacists such as Chen and his patient fills the gaps in care between visits with physicians.[14] Additionally, consistent and personalized monitoring reduces health care costs by preventing emergency situations and expensive hospital admissions. In a recent *New York Times* article, "Pharmacists Take Larger Role on Health Team," Reed Abelson and Natasha Singer find that patients rely on the care provided by pharmacists and often view their pharmacist as a "personal health coach." By providing personalized and comprehensive health counseling, the expanding role of pharmacists offers a solution to the shortage of primary care doctors.[15] Many articles have highlighted the important roles pharmacists play in improving medical therapy management and patient health outcomes.[16]

Unfortunately, when pharmacies have attempted to collaborate in the past they have encountered unnecessary antitrust obstacles. The health care guidelines do not address collaboration by pharmacies. The guidelines permit collaboration when providers can integrate to help control utilization; however, since pharmacies only dispense and do not prescribe they are unable to meet this threshold requirement for collaboration under the guidelines. The FTC has approved only three pharmacy joint ventures to provide health care services under the guidelines and none in the past decade. None of the ventures approved were able to succeed.

Moreover, an inability to collaborate only increases the disparity of power between pharmacies and PBMs and ultimately harms consumers.[17] PBMs have substantial monopsony or oligopsony power and are able to use this power to reduce compensation which harms the ability of community pharmacies to provide adequate services.[18] With this power, PBMs, either individually or collectively, are able to drive compensation below competitive levels, or in the case of PBMs that are owned by pharmacies, engage in exclusionary conduct to drive consumers

away from their pharmacy of choice. The result is that the ability of community pharmacies to compete is diminished, thereby reducing consumer choice, increasing waiting times, and increasing quality-adjusted prices for consumers. Consumers who prefer the level of personal service they receive at their independent pharmacy suffer.

Pharmacists may play an important role in coordinating with physicians and other health care providers within accountable care organizations—their close and ongoing connection with consumers may be vital to monitoring health care outcomes, providing advice and improving drug adherence. Community pharmacies are also highly technologically connected, providing them the important groundwork to have access to patients medical records which will help them coordinate care with other providers.

However, if pharmacists are unable to band together to participate with ACOs, those ACOs may be limited to simply dealing with one of the two chain pharmacies that dominate the market. Allowing community pharmacies to band together to provide services for ACOs and negotiate with ACOs will improve competition and permit ACOs to provide the highest quality access. Any new guidance provided by the antitrust agencies should allow pharmacists or other groups of providers who wish to contract with an ACO to do so on a joint basis.

Recommendation:

Any revised guidelines should clarify that pharmacies can band together to form networks to participate in ACOs. There should be an explicit safe harbor for pharmacy networks. In addition, Congress should consider legislation to give pharmacies an antitrust exemption to collectively negotiate.

V. The unspoken concern: Provider market power

Since reform has been enacted some commentators and journalists have raised concerns that reform may not succeed because there are instances where there are powerful providers, primarily hospitals, and these providers may use their power to rapidly increase costs.[19] This raises an important concern, which certainly should be carefully evaluated by antitrust enforcers and regulators. But we need to put the concern in perspective.

First, size is not necessarily problematic, nor is size necessarily indicative of "market power" in antitrust terms. Size is particularly a two-edged sword in health care markets. Some of the largest hospitals that may appear to raise competitive concerns are the most innovative and effective at cost control. Moreover, many of these hospitals have very strong commitments to the community and underserved populations.

Second, unlike the record involving health insurance, provider markets, including hospital markets, are far less concentrated than health insurance markets. Moreover, unlike the situation in health insurance, the empirical record is less than transparent that provider size has led to higher prices. And unlike health insurance markets, there is no record of competition and consumer protection violations.

Third, as suggested earlier some forms of provider power may be important for providers to be able to forestall anticompetitive or deceptive conduct by far more powerful health insurers.

Fourth, for one group of providers, hospitals, the FTC has done an admirable job in reviving merger enforcement in the past several years. Recent cases against the Evanston/Northwestern and Inova/Prince William hospital mergers have demonstrated the importance of antitrust enforcement in preventing the creation of market power. A recent action against an acquisition of two outpatient imaging centers, by Carilion Clinic, the dominant hospital system in Roanoke demonstrates how even smaller acquisitions of outpatient clinics may be anticompetitive. These clinics were potential competitors to the hospital and their acquisition harmed competition.

But the actual record on whether nonhospital provider groups possess market power seems less clear from the perspective of the enforcement agencies. I reviewed all past health care enforcement actions for the past 20 years and was surprised to find that the last time the FTC or DOJ brought an enforcement action against a group of health care providers based on market power concerns was 1994.[20] Actually, in the vast majority of cases brought against the so-called physician negotiating groups, almost none had an allegation that these groups actually possessed market power.

The lack of enforcement actions against providers seems somewhat surprising. Certainly the agencies have conducted numerous investigations of provider group mergers or other types of joint ventures and have not brought any enforcement actions. It is unclear why there is no enforcement, but this suggests that we should be cautious in too readily suggesting concerns from provider size.

In any case, the agencies clearly need to focus greater attention in those situations where providers may possess market power. The agencies should use their full panoply of powers in addressing potential anticompetitive conduct. It is interesting to observe that the case brought against the *Home Oxygen* joint venture was under Section 5 of the Federal Trade Commission Act which declares illegal "unfair methods of competition." The FTC can play an important role at looking certain kinds of competitively harmful conduct by large provider groups under its Section 5 authority.

VI. Recommendations for revitalizing competition and consumer protection enforcement

Ultimately, strong consumer protection and antitrust enforcement on the federal level is essential for health care reform to work. Below are some recommendations for building a solid structure for competition and consumer protection enforcement in health care.

1. **The Obama administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious, and deceptive conduct by insurers**. The structure of the health insurance market is broken and the evidence strongly suggests a pervasive pattern of deceptive and egregious practices. Health

insurance markets are extremely concentrated, and the complexity of insurance products and opaque nature of their practices make these markets a fertile medium for anticompetitive and deceptive conduct.

2. **Create a vigorous health insurance consumer protection enforcement program.** The FTC's health care consumer protection enforcement currently focuses on marketers of clearly sham and deceptive products. This is unfortunate. In many other areas, such as financial services, the FTC uses a broad range of powers, including studies, workshops, policy hearings, legislative testimony, and industry conferences to better inform marketplace participants of how to properly abide by the law. The FTC should adjust its health care consumer protection enforcement to focus on health insurers, and other health care intermediaries such as PBMs. These efforts should focus both on enforcement to prevent egregious and fraudulent practices and to assure that there is a sufficient amount of information and choice so that consumers can make fully informed decisions. Because of the importance of these issues, especially in controlling health care costs, the FTC should establish a new division for health insurance consumer protection.

3. **Reinvigorated enforcement against anticompetitive conduct.** The DOJ and the FTC need to reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should scrutinize anticompetitive conduct and use its powers under Section 5 of the FTC Act. As this committee knows, Section 5 of the FTC Act can attack practices which are not technical violations of the traditional antitrust laws, the Sherman and Clayton Acts. Thus the FTC can use that power under Section 5 to address practices which may not be technical violations of the federal antitrust laws, but still may be harmful to consumers. As I have testified elsewhere, the FTC should begin to use that power under Section 5 to attack a wide range of anticompetitive and egregious practices by health insurers and PBMs.

4. **Conduct a retrospective study of health insurer mergers.** I and the American Hospital Association have suggested elsewhere that one approach to this issue would be for the FTC or the DOJ to conduct a study of consummated health insurer mergers. One of the significant accomplishments of the Bush administration was a retrospective study of consummated health insurance mergers by the Federal Trade Commission. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical tools for addressing health insurance mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.

5. **Recognizing that the insurer does not represent the consumer.** Although insurers do help to control cost, they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the consumer interest, but rather exploit the lack of competition, transparency, and the opportunity for deception to maximize profits.

6. **Clarify the jurisdiction of the FTC to bring enforcement actions against health insurers.** Some may suggest that the FTC lacks jurisdiction over health insurance. I urge this committee 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.

Endnotes

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[1] I am the former policy director of the Federal Trade Commission and was actively involved in several health care matters and revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care in that role. I currently represent several consumer organizations, as well as several provider groups in ongoing investigations before the Federal Trade Commission. This testimony represents solely my own views.

[2] For a very thoughtful analysis of the ACO model and the new regulatory challenges *see* Douglas A. Hastings, "Constructing Accountable Care Organizations: Some Practical Observations at the Nexus of Policy, Business, and Law" Health Law Reporter (2010); and Douglas A. Hastings, "Accountable Care Organization Regulation and Enforcement: Coordinated or Siloed?" Health Law Reporter (2010).

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

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

[5] *West Penn Allegheny Health System v. UPMC and Highmark, Inc.*.

[6] In contrast, in one of the few DOJ cases—a challenge to an association of Arizona hospitals that had agreed to depress the wages of traveling and visiting nurses—there was successful private litigation which led to a proposed settlement of over $22 million in damages for a class of harm to nurses. *Doe v. Arizona Hospital and Health care Association*, Case No. 2:07-cv-01292 (D. AZ. 2007). I was co-lead attorney for the class of nurses.

[7] The chronic competition and consumer protection problems are detailed in David A. Balto, Testiomony 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.

[8] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses" (2009), available at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltl.pdf.

[9] American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update."
[10] *U.S. v. Blue Cross Blue Shield of Michigan*.
[11] Sens. Herb Kohl, Patrick Leahy, Dianne Feinstein, Sheldon Whitehouse, and Arlen Specter, Letter to Assistant Attorney General Christine Varney and Chairman Jon Leibowitz, November 3, 2009.
[12] Statement of the AMA for the ACO Workshop, September 27, 2010.
[13] FTC/CMS Workshop on Accountable Care Organizations, "Remarks of FTC Chairman Jon Leibowitz as Prepared for Delivery" (2010), available at http://www.ftc.gov/opp/workshops/aco/docs/leibowitz-remarks.pdf.
[14] Karen Ravn, "Clinical pharmacists can fill in health care gaps," *The Los Angeles Times*, November 30, 2009, available at http://www.latimes.com/features/health/la-hew-pharm-clinical30-2009nov30,0,1611061,print.story.
[15] Reed Abelson and Natasha Singer, "Pharmacists Take Larger Role on Health Team," *The New York Times*, August 13, 2010, available at http://www.nytimes.com/2010/08/14/health/14pharmacist.html.
[16] *See* Jim Merkel, "Independent Pharmacies: Not just a pill place," *Suburban Journals*, August 24, 2010, available at http://www.stltoday.com/suburban-journals; s*ee also* Guy Boulton, "Pharmacists play key role in program to trim health care costs," *The Journal Sentinel*, May 12, 2010, available at http://www.jsonline.com/features/health/93517939.html.
[17] For an extensive discussion of this imbalance in bargaining power, see David A. Balto, Testimony before the House Judiciary Committee Antitrust Task Force on the Impact of our Antitrust Laws on Community Pharmacies and Their Patients, October 18, 2007.
[18] As Judge Hopkins in an antitrust case brought against PBMs has observed, "By conspiring to hold down prices paid to independent pharmacies (among other alleged action), PBMs would bankrupt those pharmacies, thereby capturing a larger segment of the insurance paid prescription market for the PBM's own prescription dispensing business and allowing the PBMs to charge higher prices for that service." *N. Jackson Pharm., Inc. v. Express Scripts, Inc.*, 345 F. Supp. 2d 1279, 1292 (N.D. Ala. 2004).
[19] *See* Steven Pearlstein, "Health Care's Dilemma: Competition or Collaboration?" *The Washington Post*, November 23, 2010; *see also* Robert Pear, "Consumer Risks Feared as Health Law Spurs Mergers," *The New York Times*, November 20, 2010.
[20] In the *Matter of Home Oxygen and 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).