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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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.

[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

[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

[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).