ANTITRUST LAWS AND THEIR EFFECTS ON HEALTHCARE PROVIDERS, INSURERS AND PATIENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON COURTS AND COMPETITION POLICY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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ANTITRUST LAWS AND THEIR EFFECTS ON HEALTHCARE PROVIDERS, INSURERS AND PATIENTS

WEDNESDAY, DECEMBER 1, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COURTS AND
COMPETITION POLICY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:30 a.m., in room 2141, Rayburn House Office Building, the Honorable Henry C. "Hank" Johnson, Jr. (Chairman of the Subcommittee) presiding.

Present: Representatives Johnson, Conyers, Gonzalez, Polis, Coble, and Goodlatte.

Staff Present: (Majority) Christal Sheppard, Subcommittee Chief Counsel; Anant Raut, Counsel; and E. Stewart Jeffries, Minority Counsel.

Mr. JOHNSON. This hearing of the Committee on the Judiciary, Subcommittee on Courts and Competition Policy will now come to order. Without objection, the Chair is authorized to declare a recess.

Welcome to the final hearing of the Subcommittee on Courts and Competition Policy in the 111th Congress. I want to start by saying how much I have enjoyed working with my colleagues on both sides of the aisle these past 2 years. We have had our share of healthy differences, but we have also passed a number of important pieces of legislation on a bipartisan basis.

In particular, I can't say enough about the Ranking Member of the Subcommittee, the Honorable Howard Coble, and how integral his presence and friendship has been to the success that we have enjoyed together. Thank you, Howard.

Now, on today's hearing, doctors are under pressure from all sides to find ways to coordinate patient care. Coordinated care can help patients by reducing costs and improving outcomes. It may involve sharing patient medical data, tracking outcomes across a population, or jointly contracting to provide a seamless continuum of care. But the question for many doctors is: How do you coordinate patient care without violating the antitrust laws?

One of my first acts as Subcommittee Chairman was to write a letter to Chairman Leibowitz of the Federal Trade Commission regarding the $19 billion in incentives for health industry—excuse me, health information technology investments under the American

Recovery and Reinvestment Act of 2009. I asked him to provide physicians with clear guidance on how to take advantage of these incentives and integrate their practices in a way that did not violate the antitrust laws.

In addition, I asked whether the FTC's enforcement practices against physician collective negotiation have resulted in any appreciable decrease in patient premiums or increase in competition. I was gratified by Chairman Leibowitz's prompt response assuring me that the FTC only initiates actions against collective negotiations in situations where there has been demonstrable harm to consumers in the form of reduced competition and higher prices. But I am concerned that the FTC and DOJ may be spending their resources going after the small, easy cases instead of tackling the larger systemic issues which actually result in greater societal harm.

According to an American Medical Association study, 96 percent of major metropolitan cities have a concentrated health insurance market. While concentration can lead to efficiencies, it can also create distortions in the market, resulting in fewer choices and higher premiums. I am happy to see that the DOJ recently announced an investigation into Blue Cross Blue Shield of Michigan's alleged anticompetitive practices. While I applaud the DOJ's efforts, I remain concerned about the many other areas in this country where a single dominant health insurer wields absolute power.

My goal in many areas as a legislator is to strike a balance. I believe that that is the heart of competition policy, and should be here as well. I am not blind to the concern that providing physicians and hospitals with more bargaining power can lead to higher healthcare costs. At the same time, if we allow the status quo to continue, we risk creating a long-term doctor shortage as physicians are driven out of their specialties by the imbalance in bargaining power and new doctors are discouraged from entering.

It is fine and good to say that we should respect the free market, but the free market only works if the antitrust laws are enforced evenly against both sides. In this past week alone, articles in the Wall Street Journal, New York Times, and the Washington Post highlighted the challenges and opportunities that hospitals and healthcare providers will face under the new healthcare laws. How the antitrust laws are enforced against all parties involved will, in part, determine how successful these initiatives turn out to be.

I now recognize my colleague Howard Coble, the distinguished Ranking Member of the Subcommittee, for his opening remarks.

Before I close, I must give kudos to my staff, who have made me look taller in this Chair than I actually am. I want to thank them publicly for their great work.

Now, Mr. Coble.

Mr. COBLE. Thank you, Mr. Chairman. We are all obliged to our staff, Mr. Chairman, so I share that.

I thank you, Mr. Chairman, for your generous words earlier. I, too, have very much enjoyed serving as the Ranking Member of this Subcommittee and commend you for having been a very good Chairman with whom to work for the past 2 years. I thank you for that. Thank you as well for calling this important and timely hearing.

Physicians have long been concerned with what they view as increasing concentration among health insurers. This concentration has led to lower reimbursement rates for physicians. That, coupled with the high and continuing rising cost of malpractice insurance, has caused many physicians not only in my district but I think nationally to consider abandoning the practice of medicine.

To combat these forces, many physicians and hospitals have tried various forms of clinical integration to try and help contain costs and negotiate better reimbursement rates from insurers. Unfortunately, many of these clinical integration schemes have come under antitrust scrutiny by the FTC and DOJ as potential price-fixing arrangements.

The FTC and DOJ have provided some guidance on what types of arrangements physicians can lawfully employ. However, these healthcare guidelines were released in August 1996, and that was almost a decade and a half ago. I know that there have been a host of changes in medical malpractice since that time. I have heard complaints from medical professionals that these guidelines no longer reflect market realities. I would like to ask Mr. Feinstein and Mrs. Pozen why these guidelines have not been revised, and are there plans to do so?

In addition, it is my understanding that physicians can try to obtain a business review letter from the agencies; however, it is also my understanding that these letters can take a very long, extended time to come to fruition and can cost thousands, I am told, in legal fees. And this is not necessarily practical for many physicians.

The discussion is particularly relevant, Mr. Chairman, it seems to me, given the Department of Health and Human Services is currently devising rules regarding accountable care organizations, or ACOs. These ACOs have the potential to reduce costs for consumers and to be beneficial for physicians as well. However, some have raised concern that the ACOs could also be used to facilitate price fixing. Physicians clearly want and need clear guidance in this arena, and I am hoping that HHS, along with DOJ and FTC, will be able to provide that to them.

Physicians are not the only parties at issue here. The guiding principle of antitrust law is that it is supposed to promote consumer welfare through competition. This, of course, means generally lower prices, better services, and greater innovation in products and services. However, I feel that patients often get lost in these discussions about healthcare.

What I would most like to hear from our witnesses, Mr. Chairman, is whether they feel that current antitrust enforcement truly serves the needs of patients, and, if it does not, what can be done to improve that. I look forward to hearing the answers to these and other questions, and yield back the balance of my time, Mr. Chairman. But before doing so, if I may, I would like unanimous consent to have introduced into the record statements from the Ranking Member of the full Committee Lamar Smith, the statement from the National Community Pharmacists Association, and the American Medical Association.

Mr. JOHNSON. Without objection.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF THE HONORABLE LAMAR SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND RANKING MEMBER, COMMITTEE ON THE JUDICIARY

Statement of Judiciary Committee Ranking Member Lamar Smith
Subcommittee on Courts and Competition Policy
Oversight Hearing on "Antitrust Enforcement Trends in Health Care"
Wednesday, December 1, 2010
(Final)

For many years, doctors and hospitals have expressed concerns about consolidation among health insurers. They fear that mergers among health insurers result in lower reimbursement rates for doctors.

Some doctors claim that the Department of Justice has allowed these health insurance mergers to go through largely unchallenged. At the same time, they contend that both DOJ and the Federal Trade Commission have brought a number of antitrust suits against physician and hospital groups.

Doctors believe that they are unfairly targeted by the agencies with these suits and that the agencies have given little clear guidance on the ways that physicians strengthen their negotiating position towards insurers.

For their part, both the FTC and DOJ defend their enforcement priorities. They claim that the cases they bring against doctors and hospitals are necessary to prevent price-fixing arrangements that would ultimately drive up costs for all consumers.

They further contend that, despite the physicians' claims, they do pursue antitrust cases against health insurers, such as

DOJ's recent case against Blue Cross/Blue Shield of Michigan, when it is proper to do so.

Today's hearing, which features witnesses from the enforcement, health insurance, and physician communities, will give us an opportunity to fully explore these issues.

This topic is critical and timely, given that both DOJ and the FTC are providing guidance on the formation of Accountable Care Organizations or ACOs. These ACOs were created as part of the majority's health care bill that President Obama signed into law this year.

Several news organizations have reported that physician groups and hospitals are lobbying to obtain antitrust exemptions as part of the ACOs.

As a general matter, exemptions from the antitrust laws should be granted only by Congress and not by agencies. I hope this hearing will give us some clarity on whether any changes to the antitrust laws are warranted.

While we can debate the merits of the agencies' health care antitrust enforcement priorities, what is beyond debate is that Obamacare did virtually nothing to offset one of the biggest costs that physicians must bear: meritless malpractice suits.

According to a study published in the *New England Journal of Medicine*, 40 percent of medical malpractice suits filed in the United States are meritless. Every doctor must

purchase malpractice insurance at great expense to protect against these frivolous lawsuits.

The threat of liability causes many doctors to practice defensive medicine. They order unnecessary tests and procedures that do not benefit the patient in order to shield themselves from potential lawsuits.

A recent Pacific Research Institute study estimates that defensive medicine costs $191 billion a year, while a PricewaterhouseCoopers study put the figure at almost $240 billion.

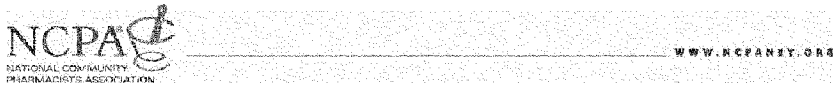
All these costs are then passed on to patients in the price of health care. In fact, the Congressional Budget Office conservatively estimates that if Congress enacted civil justice reform, it could reduce the deficit by $54 billion over the next ten years.

That's why some states—including my home state of Texas—enacted tort reform to limit the amount of excessive damages awarded in frivolous suits. The result? Insurance premiums have fallen 30 to 40% and the availability of medical care has expanded. That means Texans and others could pay less to have more options and better health care.

With that, I yield back the balance of my time.

[The prepared statement of the National Community Pharmacists Association follows:]

PREPARED STATEMENT OF THE NATIONAL COMMUNITY PHARMACISTS ASSOCIATION



Statement of the National Community Pharmacists Association (NCPA) to the United States House of Representatives Committee on the Judiciary; Subcommittee on Courts and Competition Policy Hearing Regarding Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients.

December 1, 2010

Chairman Johnson, Ranking Member Coble, and members of the Subcommittee:

NCPA welcomes this opportunity to provide input and suggestions regarding the antitrust laws and their effects on healthcare providers, insurers and patients particularly as they relate to pharmacy care providers. NCPA represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation's independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation's retail prescription medicines.

The Lack of Existing Antitrust Guidance for Pharmacists May Hinder Participation in Accountable Care Organizations (ACOs) and Other Collaborative Care Models Envisioned in the Affordable Care Act.

The Affordable Care Act establishes a new category of health care structure—the accountable care organization (ACO) within the Medicare program, with rules for provider participation and principles for sharing in the savings generated by this coordinated method of health care delivery. The federal Act also specifically references the critical role that pharmacists can play in ACO's as well as in similar entities such as "medical homes", "transition of care" teams, and "medication reconciliation activities."

Pharmacists are increasingly gaining recognition for the integral role that they play in encouraging preventative care and promoting wellness, given their subject matter expertise and access to the communities in which they serve. Allowing pharmacists to collaborate and negotiate with insurers to deliver patient care services and serve as patient advocates in exchange for adequate reimbursement for these activities will ensure that more consumers—both in Medicare ACOs and in private plans—will have access to this type of innovative care, resulting in a reduction in overall healthcare costs.

Although pharmacists are mentioned in the context of participation in ACOs in federal healthcare reform, the majority of helpful guidance that has been issued to health care providers on the topic of navigating potential anti-trust concerns in collaborative care models has been virtually limited to physicians and hospitals. The FTC and DOJ jointly issued the *Statements of Antitrust Enforcement Policy in Healthcare* in 1996 to provide guidance to health care providers and related entities about the agencies' enforcement policies in this area and to provide examples of types of collaboration among these providers or entities that the agencies would not challenge as violative of the antitrust laws—or those within antitrust "safety zones."

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The permissible scenarios cited in the 1996 health care guidelines are primarily focused on collaborative efforts among physicians or hospitals and do not mention pharmacists, pharmacies or other types of healthcare providers. In a Statement to the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights Regarding the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Oversight, NCPA recommended that the FTC/DOJ revise the 1996 *Antitrust Enforcement Policy in Healthcare Guidelines* to include pharmacist and other types of health care provider collaboration. Despite those efforts, there has been no progress to date in the ability of pharmacists to work collaboratively and, in fact, the FTC has on numerous occasions proactively worked to prevent that from occurring by submitting unsolicited comments in opposition to prior attempts by pharmacists to act collaboratively on behalf of patients.

FTC Guidelines Should be Updated to Include a "Safe Harbor" Provision That Would Allow Pharmacies to Collaborate in Order to Participate in ACOs and Other Collaborative Care Models.

Given the fact that antitrust laws enforced by the FTC will apply to the ACOs that will operate in the new Medicare program, NCPA recommends that the FTC provide additional guidance to those allied health care providers, such as pharmacists, that are likely to be included in these entities. Such guidance could take the form of an updated *Statements of Antitrust Enforcement in Health Care* that could potentially address the role of pharmacists in ACOs and other types of collaborative care models, or the FTC could solicit input from affected parties in order to provide guidance to HHS and CMS specifically with regard to the role of pharmacists/allied health care providers in the new Medicare ACO program. This is particularly important in the case of independent pharmacies that do not have the already-existing infrastructure of regional and large chains to contract with an ACO or medical home to offer services and negotiate terms of participation.

In order to encourage participation in collaborative care models that include a variety of health care providers, such providers need to have clear guidance from the FTC as to the parameters of acceptable collaboration or those activities that would fall beneath antitrust "safety zones." NCPA recommends that the FTC revise *the Statements of Antitrust Enforcement Policy in Healthcare* to expressly permit independent pharmacies to collaborate with one another in order to be able to participate in ACOs and other collaborative care models.

[The prepared statement of the American Medical Association follows:]

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION (AMA)

STATEMENT

of the

American Medical Association

to the

Subcommittee on the Courts and Competition Policy, Committee on the Judiciary United States House of Representatives

RE: Antitrust Laws and Their Effects on Health Care Providers, Insurers and Patients

December 1, 2010
[Revised Version, 12/7/10]

Division of Legislative Counsel
202 789-8510

STATEMENT

of the

American Medical Association

to the

Subcommittee on the Courts and Competition Policy
Committee on the Judiciary
United States House of Representatives

RE: Antitrust Laws and Their Effects on Health Care Providers, Insurers and Patients

December 1, 2010

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on antitrust laws and their effects on health care providers, insurers and patients. We commend Chairman Conyers, Ranking Member Smith, Subcommittee Chairman Johnson, Subcommittee Ranking Member Coble, and Members of the Committee for addressing these important antitrust issues.

The AMA believes that there are two distinct matters of health care antitrust law currently at issue: 1) health insurer market concentration, and 2) antitrust barriers to physician engagement in accountable care organizations (ACOs). Previously, the AMA has pointed out that the enforcement of antitrust law against insurers and physicians has been imbalanced. We have been working directly with the Department of Justice (DOJ) and the Federal Trade Commission (FTC) to address that concern. In addition, most recently we have focused on the Affordable Care Act's (ACA) authorization of programs and pilots to test innovative care delivery systems, such as ACOs, and the impediment of current antitrust enforcement to physician leadership in those models. On that topic, too, we have been engaged in a productive dialogue with the FTC and DOJ. Our comments below examine both matters, and draw from some of the our previous correspondence to Congress and the agencies on these issues.

Antitrust & Health Insurers[1]

I. Health Insurer Market Shares and Market Concentration

Every year for the past ten years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The AMA's most recently published

[1] Our comments on antitrust and health insurer market power draw from the AMA's July 8, 2009 letter to Christine Varney, Assistant Attorney General for Antitrust, DOJ, re: Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update).

study, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2010 update)" (the study), is intended to help researchers, policy makers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care and on the economy. The study reports health insurer shares and Herfindahl-Hirschman Indices (HHIs) for combined HMO and PPO markets and separate HMO and PPO markets in 46 states and 359 smaller geographic areas across the United States (metropolitan statistical areas, or MSAs).[2,3] Key findings in this study are as follows. Considering combined HMO and PPO product markets:

- 80 percent (286) of the MSAs examined are highly concentrated based on the revised DOJ/FTC Horizontal Merger Guidelines.[4]
- In 96 percent (344) of the MSAs, one or more insurers had a market share of 30 percent or greater.
- In 48 percent (171) of the MSAs, at least one insurer had a market share of 50 percent or greater.
- In 18 percent (63) of the MSAs, one insurer had a market share of 70 percent or greater.

Independent academic researchers, examining different data, have reached similar conclusions. For example, Dafny, Duggan and Ramanarayanan (2009) estimate that the fraction of local markets falling into the "highly concentrated" category (per the DOJ's 1997 Horizontal Merger Guidelines) increased from 68 to 99 percent between 1998 and 2006.[5]

II. Barriers to Entry

The existence of health insurer market power may be inferred in most of the health insurance markets examined in the AMA's study. *United States v. Grinell Corp.*, 384 U.S. 563, 571 (1966)(the existence of market power "ordinarily may be inferred from the predominant share of the market"). The AMA is aware that the influential Seventh Circuit opinion (*Ball Memorial Hospital v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325, 1325 (7th Cir. 1986)), authored 20 years ago by Judge Easterbrook, concluded that the health insurer defendant's high market share did not establish market power because entry barriers in health insurance were low. All that was required, reasoned the court, was a license and money, "which may be supplied on a moment's notice," and "no firm has captive customers." *Id.*, at 1335-36.

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[2] The product market excludes Medicare and Medicaid because a significant number of consumers are not eligible for these programs. Thus, Medicare and Medicaid are not substitutes for commercial insurance. The localized geographic market is supported by the observation that most health insurers market locally because employers, employees and other individuals purchase health insurance products that will serve them in proximity to where they work and live.

[3] The smaller geographic areas include MSAs and metropolitan divisions as defined by the U.S. Office of Management and Budget. The vast majority of these are MSAs, while a few of them are metropolitan divisions, which are subcomponents of very large MSAs (e.g., New York, Chicago). For convenience, both of these smaller areas are referred to as MSAs throughout the report.

[4] A key statistic reported in the study is the percentage of health insurance markets in the U.S. that are highly concentrated based on the DOJ/FTC Horizontal Merger Guidelines. The study summarized this information based on the 1997 guidelines. Under the 1997 guidelines, markets were considered highly concentrated if they had an HHI greater than 1800. New guidelines released in August 2010 – after the study was published – increased the threshold to 2500. Raising that threshold means fewer markets meet the definition of highly concentrated, and the study's findings now reflect that 80 percent of the MSAs examined are highly concentrated.

[5] Dafny, L., Duggan, M., and Ramanarayanan, S., 2009. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," unpublished working paper.

The intervening 20 years have demonstrated that the Seventh Circuit in *Ball Memorial* did not consider the significant barriers that we now know exist, and the assumptions on which the court relied have proven false. It is now well understood that many barriers to entry exist, including: state regulatory requirements; brand name acceptance of established insurers; developing sufficient business to permit the spreading of risk; contending with established insurance companies that have built long-term relationships with employers and other consumers; and the cost of developing a health care provider network. *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July, 2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. The AMA testified at these hearings in opposition to the proposed merger. Significant evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry.[6] The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets.[7] In a report commissioned by the Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.[8]

LECG's conclusion is consistent with the federal antitrust enforcement agencies' observation that national insurers have been unsuccessful in entering some of the Blue Cross-dominant markets in recent years.[9] For instance, Rob McCann reports that Blue Cross Blue Shield of

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[6] The Department held three public hearings, in which 101 interested parties offered comments, and compiled a Web site that hosted nearly 50,000 pages of commentary. The proposed merger was also the subject of two United States Senate Judiciary Committee hearings. The extensive record included the analysis of financial and economic experts such as LECG, Monica Noether of CRA International, the Blackstone Grays and others. See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts' reports.

[7] Dr. Monica G. Noether. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filing for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Test From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available at *www.ins.state.pa.us*; Accessed 07/29/2008. (Noether Report, pp. 8-11).

[8] LECG Inc., "Economic Analyses of The Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.

[9] "Improving Health Care: A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at pp. 8-11.

Michigan has had "market dominance for decades." Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook, p.42 (Thomson West 2007).

Some market barriers are created by contracting practices used by dominant health insurers. These include most favored nations clauses whereby physicians must agree to give the dominant payor at least as favorable a rate as they give to any other insurer. Other problematic contracting practices include all products clauses, anti-assignment provisions and minimum enrollment assurances. *See Id.*, at pp.46-49.[10] The Highmark/IBC hearings also highlighted how market division arrangements prevent entry and allow entrenched firms to maintain market power.

There is a consensus among health economists that most health insurance markets are not perfectly competitive, and as a result, large insurers can exercise market power. A new research study by Northwestern University Professor Leemore Dafny, PhD, published by the prestigious *American Economic Review*, finds evidence that health insurers exercise at least some market power in an increasing number of geographic markets.[11] Dr. Dafny concludes that it takes more than ten insurers in a market before market power is eliminated. A study by Dranove *et al.* published in the *Journal of Industrial Economics* reaches similar conclusions.[12]

III. Health Insurers Possess and Exercise Monopsony Power

Concentration data reported in the AMA's study can be used to study health insurer monopsony power. One reason is that the geographic market in which an insurer sells its services to consumers coincides with the geographic market from which it secures services from physicians and other health care providers. Supporting this conclusion is the observation that patients will travel for hospital and physician services only within narrow geographic limits. Therefore, employers want health insurance coverage for their employees in each of the locales where the employees reside or work. Responding to this preference, health insurers must obtain physician coverage in each locale. Moreover, physicians invest and develop their practices locally. Physicians are not mobile and must sell their services to health insurers controlling any significant portion of their practices.

The AMA's study indicates that numerous insurers possess the sort of monopsony power in physician markets that the DOJ claimed to exist in its challenges of UnitedHealthcare's acquisition of PacifiCare[13] and Aetna's acquisition of Prudential's national health insurance lines.[14] In those cases, the DOJ embraced the notion of a localized market in which health insurers purchase physician services.[15]

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[10] Available at *http://www.drinkerbiddle.com/People/detail.aspx?id=996&MainAuthors=996.*

[11] Dafny L., 2010 "Are Health Insurance Markets Competitive?" *American Economic Review.*

[12] Dranove, D., Gron, A. and M. Mazzeo, 2003, "Differentiation and Competition in HMO Markets" *Journal of Industrial Economics.*

[13] Complaint *U.S. v. UnitedHealthcare Group, Inc.*, No. 1:05CV02436 (U.S.D.C. December 20, 2005) [hereinafter United-PacifiCare Complaint].

[14] *U.S. v. Aetna Inc.*, No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at *http://www.usdoj.gov/atr/cases/f2500/2501.pdf*; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf.*

[15] See e.g. Aetna Complaint ¶ 20 (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas).

The nature of the health care industry facilitates the potential for a health insurer possessing any significant market share to exercise monopsony power over physicians selling health care services within the health insurer's market. If physicians were to refuse the terms of the dominant buyer, they would likely suffer an irretrievable loss of revenue. Medical services can neither be stored nor exported, and it is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.[16] Consequently, a physician's ability to consider realistically terminating a relationship with a health insurer because of low reimbursement rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. Where those alternatives are lacking, a health insurer will have the ability to reimburse physicians at rates that are below a true competitive level. Health economist Cory Capps, PhD has concluded that this monopsony injury can occur at a health insurer market share of less than 35 percent.[17] Given that in 96 percent of MSAs, one or more insurers possess a market share of 30 percent or greater (see summary of study findings at page 2 *supra*),[18] it is critical for antitrust enforcers to maintain a competitive market in which physicians have adequate competitive alternatives.

IV. Consumer Injury

In an era of spiraling costs, it is tempting to conclude that anything that drives down medical fees, such as monopsony, is a good thing for consumers. But it is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.

Health insurer monopsonists typically are also monopolists. Therefore, their lower input prices (for physician services) do not necessarily lead to lower output prices (i.e., health insurance premiums).[19] As a general proposition, monopsonists drive down their buying price by purchasing fewer products. Because there is less product purchased, there is, in turn, less product sold, which leads to higher output prices. That lower physician fees paid by monopsonist insurers may result in higher premiums to patients was emphasized by R. Hewitt

[16] As alleged in the *United/PacifiCare* complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost. Complaint at paragraph 37.

[17] Capps, C., 2009, "Buyer Power in Health Plan Mergers," Journal of Competition Law & Economics.

[18] Bearing in mind that the concentration data cited earlier only consider commercial insurance, some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, health economist, David Dranove, PhD, the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern's Kellogg of Management, explains why Medicare and Medicaid do not make good alternatives for physicians dealing with a monopsonist insurer. (*See* affidavit of Professor David Dranove in *United States v. UnitedHealth Group, Inc., and Sierra Health Services, Inc.*). According to Professor Dranove, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer reimbursement. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Moreover, Medicaid reimbursements to physicians are significantly less than those from commercial health insurers. Professor Dranove concludes: "Medicare and Medicaid do not represent viable alternatives for physicians who face lower fees from a monopsonist insurer. Because Medicare and Medicaid are large purchasers of physician services, excluding them from market share calculations will profoundly change inferences about market shares and monopsony power. Medicare and Medicaid should therefore be excluded when computing shares in the market for the purchase of physician services."

[19] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

Pate, a former Assistant Attorney General of the Antitrust Division, in a 2003 statement before the Senate Judiciary Committee:

> A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers.

The Pennsylvania experience is consistent with economic theory. At the conclusion of the Highmark/IBC hearings, the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would grant the merged health insurer undue leverage over physicians and other health care providers. The Department released the following statement:

> Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.

There may be antitrust concerns if a health insurer can lower compensation to physicians even if it cannot raise prices to patients. For example, in the United/PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase. *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light.* 74 Antitrust L.J 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers). Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger,* Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), *available at http://www.usdoj.gov/atr/public/speeches/3924.wpd.*

Reductions in service levels and quality of care cause immediate harm to consumers. In the long run, we must also consider whether monopsony power will harm consumers by driving physicians from the market. Recent projections by the Health Resources and Services

Administration suggest a looming shortage of physicians in the United States.[20] Moreover, a recent study by Merritt Hawkins and Associates tracked the viewpoints of physicians between the ages of 50 and 65 (which comprise 36 percent of the physicians in the United States, according to the AMA).[21] The survey found that more than 49 percent of physicians in this population are planning to make a change in their practices that will either eliminate or reduce the number of patients they treat due to frustrations with inadequate reimbursement in the face of continually increasing overhead and administrative and regulatory burdens that detract from actual patient care. The continued exercise of monopsony power will exacerbate this looming shortage.

V. Recommendations for Additional Steps

The AMA believes that there must be more rigorous antitrust enforcement in health insurance markets. Restoring competition in the marketplace for the purchase of physician services will improve the quality of care, redress the looming shortage of physicians and lower premiums and the AMA urges that this be a top priority for the Congress and the antitrust enforcement agencies. The AMA has suggested a number of steps that the DOJ should consider in connection with this effort:

1) perform a retrospective study of health insurance mergers analogous to that performed by the Federal Trade Commission on hospital mergers;
2) commission new research to identify causes and consequences of health insurer market power;
3) create a framework for predicting the effects health insurer mergers will have on consumer and provider markets; and
4) gather information that would facilitate additional systematic studies.

Antitrust Barriers to Physician Engagement in ACOs[22]

The AMA is committed to encouraging physicians to participate in the full range of innovative delivery reforms authorized in the ACA, including ACOs, which are intended to achieve the goals of higher quality and more efficient service delivery. As we noted in our August 12, 2010, letter to CMS Administrator, Donald Berwick, MD, on Section 3022 of the ACA, the Medicare Shared Savings Program, it is critical that the Administration and Congress develop delivery and payment reform policies that will enable the majority of U.S. physicians, including those who are in solo or small group practices, to participate effectively. In drafting the ACA, Congress allowed for a range of different organizational models to serve as ACOs, including physicians in "group practice arrangements" and "networks of individual

[20] See Health Resources and Services Administration, Physician Supply and Demand: Projections to 2020 (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); see also Merritt, Hawkins, et al., Will the Last Physician in America Please Turn Off the Lights? A Look at America's Looming Doctor Shortage (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).

[21] Merritt Hawkins and Associates, *2007 Survey of Physicians 50 to 65 Years Old*, available at http://www.merritthawkins.com/pdf/mha2007olderocsurvey.pdf.

[22] Our comments on antitrust and ACOs draw from the AMA's September 27, 2010 Statement to the FTC, CMS, and OIG-HHS re: the Medicare Program; Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty Laws.

practices" of physicians, because in most of the nation, patients receive their care from physicians in small, independent practices, not from large health systems. Already, there are many examples of physician groups and independent practice associations across the country that take accountability for the overall cost and quality of care for their patients without having to deliver every service, including hospital care, for their patients. **We urge the Congress and the Administration to do everything possible to facilitate physician-led ACOs and not inadvertently bias participation in favor of large health systems and hospital-dominated networks.** The AMA urges maximum flexibility in developing criteria for ACO participation in order to ensure that physician-led organizations qualify. Physicians should not have to become employed by a hospital or sell their practice to a hospital in order to participate in new delivery models. Otherwise, this will lead to significant hospital consolidation in the healthcare marketplace and reduce competition, not further it.

Policies to ensure the success of ACOs

There is no evidence showing that a particular type of provider or organizational structure is the most efficient for achieving the cost and quality objectives of the ACO provisions of the ACA. Accordingly, the ACA explicitly provides that a broad variety of entities— including group practices or networks of individual physician practice—are eligible to serve as ACOs. However, this statutory flexibility will be lost if present antitrust risks continue to be encountered by the many physicians in small or solo practices interested in forming ACOs.

As a practical matter, clinical integration efforts that are designated as ACOs for the purpose of Medicare reimbursement will need to function in commercial insurance markets as well. Creating an ACO is costly. Encouraging physician formation of ACOs requires the crafting of rules for ACOs that are transferable to the commercial health insurance market.

Unreasonable antitrust barriers must be eliminated

1. Rule of reason[23], not the per-se rule[24], must be applied to ACOs

Doctors typically practice in small firms. According to the AMA Physician Practice Information survey (2007-2008), 78 percent of office based physicians in the U.S. are in practices in sizes of nine physicians and under, with the majority of those physicians being in either solo practice or in practices of between 2 and 4 physicians.[25] The antitrust laws treat as competitors firms that practice in the same or related specialty and are in the same geographic market. Therefore, the limitations, created by the antitrust laws, on competitor collaborations would apply to the formation and operation of ACOs.

[23] The "rule of reason" has been the hallmark of judicial construction of the antitrust laws. Under its aegis, the anticompetitive consequences of a challenged practice are weighed against the business justifications upon which it is predicated and its putative pro-competitive impact, and a judgment with respect to its reasonableness is made.
[24] Per se illegality conclusively presumes the challenged practices to be unreasonable. In other words, when a per se offense (such as price fixing among competitors) is charged, all the government must establish is that the defendant has, in fact, engaged in the proscribed practice; illegality follows as a matter of law, no matter how slight the anticompetitive effect, how small the market share of the defendants, or how proper their motives.
[25] Kane, Carol K. "The Practice Arrangements of Patient Care Physicians, 2007-2008: An Analysis by Age Cohort and Gender." Policy Research Perspectives No. 2009-6. (Chicago, IL: American Medical Association, December 2009).

ACOs consisting of individual physicians and physician firms will have to negotiate fees with individual payors. The FTC and DOJ have recognized that such negotiations are not always unlawful. Under present FTC-DOJ Statements of Enforcement Policy in Health Care, ("The Statements"), such negotiations are evaluated under the rule of reason if sufficient financial or clinical integration exists. The focus in the Statements on financial and clinical integration, however, imposes restrictions on physician networks organized as ACOs that are tighter than the restrictions required by antitrust law.

Outside the health care context, courts and the Agencies themselves apply a more flexible antitrust analysis than is found in the Statements. For example, in the Agencies' Guidelines on Competitor Collaboration, the Agencies make no mention of financial or clinical integration. Instead, the Competitor Collaboration Guidelines ask more generally whether a joint venture involves "an efficiency-enhancing integration of economic activity" and whether any restraints are "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits." The Supreme Court, too, in its joint venture cases has eschewed any fixed formulation of what may constitute integration sufficient to warrant rule of reason treatment. By focusing on risk sharing and clinical integration, the Statements have stunted the development of physician joint ventures that could substantially improve care and reduce costs. The AMA hopes that the FTC and the DOJ will not apply such a ridged framework to the development of ACOs.

The Agencies' present approach to integration has its origins in the Supreme Court's decision in *Arizona v. Maricopa County Medical Society*.[26] In a 4-3 decision, the Supreme Court held that a physician networks maximum fee schedules represented *per se* unlawful price-fixing agreements. In so holding, the Court distinguished the networks from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."[27] The physicians in the defendant networks did not put up capital; they did not accept capitation, but instead billed on a fee-for-service basis. Nor did the Court observe any other indicia of integration among the physician practices that comprised the networks. Nevertheless, Justice Powell and the two justices who joined his dissent reasoned that the networks were comparable to the joint licensing arrangements held subject to the rule of reason rather than the per se rule in *Broadcast Music Inc. v. CBS*.[28]

Antitrust law has matured significantly since *Maricopa* was decided. The Supreme Court has repeatedly cut back the scope of the *per se* rule. Conduct that was once squarely within the per se rule is now subject to the rule of reason. Along with this sharp narrowing of the per se rule, are the numerous statements by the Supreme Court that the per se rule should only apply to the most blatantly naked forms of price fixing that have no plausible efficiency justifications. Given the narrowing of the per se rule and the substantial efficiencies ACOs can create, ACOs should not be evaluated under the per se rule. As the Supreme Court recognized in *Broadcast Music Inc. v. CBS* the rule of reason analysis applies to arrangements prompted by (i) the need for better service to consumers, and (ii) by reaping otherwise unattainable efficiencies. This is precisely the case with ACOs. **Therefore, the AMA**

[26] *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).
[27] Id. at 356.
[28] *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1 (1979).

strongly recommends that the Agencies explicitly recognize under Supreme Court precedents, that ACOs should be protected by the antitrust laws and their fee negotiations should not be subject to the per-se rule.

2. ACOs and financial integration: risk sharing arrangements

Risk sharing arrangements were popular in the 1990s. Since then, the market has decisively turned against risk sharing models of integration. It is thus unclear whether many physicians creating ACOs will pursue a risk sharing model. For those physicians and those markets where risk sharing arrangements are still viable, the Agencies should clarify the requirements for adequate financial integration within the context of ACOs. **Accordingly, the Agencies should acknowledge sufficient financial integration in the case of any contract employing: (1) capitation; (2) substantial withholds (15%-20%) range; (3) a percentage of premium; (4) global fees or all-inclusive case rates; (5) cost and utilization targets; or (6) any other pay-for-performance reimbursement models that involve risk.**

3. ACOs and clinical integration

Clinical integration is now an important model for physician collaboration. An understanding of the basic indicia of clinical integration has emerged over time in the market among health care policymakers, health care entities, and the antitrust agencies. The AMA in its 2008 publication entitled "Competing in the Marketplace: How physicians can improve quality and increase their value on the health care market through medical practice integration," describes some of the basic elements of a clinically integrated network as: (1) mechanisms that control utilization and establish quality benchmarks; (2) practice protocols that are designed to improve care; (3) information databases and sharing treatment information in order to streamline care and lower costs; (4) selectively choosing physicians that will actively participate in the operation of the clinically integrated network, follow the practice protocols and work towards achieving the quality benchmarks; and (5) investment of the financial capital needed to create necessary infrastructure.

The FTC/DOJ should clarify the clinical integration requirements an ACO should meet in order to avoid application of the per se rule. It is essential, however, that the FTC/DOJ not put forward ACO clinical integration requirements[29] that will themselves pose an unreasonable barrier to ACO development. The current clinical integration standards published in the Statements and 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.

[29] Section 3022 of the ACA identified requirements that a qualified ACO must meet, including an agreement that an ACO shall "define processes to promote evidenced-based medicine and patient engagement, report on quality and cost measures, and coordinated care" (see (2)(G)). The law also authorizes the Secretary of HHS to determine appropriate measures to assess the quality of care furnished by the ACO (see (3)(A)), as well as allows the Secretary to determine appropriate reporting standards related to the Physician Quality Reporting Initiative. Recognizing that HHS has the authority to establish quality measures, the AMA has provided CMS with detailed recommendations with regard to the performance measurement and reporting needs for ACOs.

Substantial cost barriers face any physician organization endeavoring to establish compliance with existing FTC/DOJ standards.[30] The MedSouth and GRIPA FTC staff advisory letters demonstrate how high the bar has been set for physician networks seeking to qualify for rule of reason treatment through clinical integration. Both MedSouth and GRIPA made significant investments in capital and resources, using a cadre of consultants and technology experts to assist in the effort. Both networks invested in electronic medical records and tracking technology to share information on their patients and to monitor data relating to utilization and medical outcomes. And both networks developed clinical practice guidelines and procedures for monitoring compliance with them. In both instances, the FTC staff advisory letters noted no apparent anticompetitive motivation for the physicians' efforts.

Despite these features, neither MedSouth nor GRIPA achieved agency approval easily or without significant caveats. Both letters reflected intensive FTC investigation of the networks' histories, purposes, contracting mechanisms, disciplinary methods for non-compliant physicians, and strategies for producing efficiencies. Each involved a searching examination of the so-called "ancillarity" of the networks' pricing mechanisms to their efficiency-enhancing potential. Each left the FTC plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce significant efficiencies. The evidence to date strongly suggests that few if any clinical integration programs will ever recover their initial investment. For example, GRIPA has not come close to recovering their investment in their efforts to comply with the FTC's standards.[31] **The clinical integration programs that the FTC has approved to date should not become the litmus test governing the adequacy of physician ACO clinical integration programs.**

4. The role of exclusive contracting

Some ACOs may need the ability to negotiate with insurers on an exclusive basis. First, ACO physicians need to participate in any contract into which the ACO enters. This requirement will insure that ACOs can offer health insurers a complete physician panel, and prevent gaps that could undermine the clinical integration program's efforts to create efficiencies. Second, ACO physicians should contract with health insurers solely through the ACO. This requirement prevents health insurers from free riding on ACO clinical integration efforts and thereby take a significant portion of the value created by these efforts. If health insurers want to benefit from the ACOs clinical integration program, they must deal with the ACO directly.

Unfortunately, today clinical integration programs are generally non-exclusive. One of the reasons clinical integration programs have developed in this manner is the uncertainty created by the absence of FTC/DOJ advisory opinions on exclusive dealing and FTC/DOJ Statements that provide little guidance. Further, the unnecessarily low safe harbor threshold of a 20 percent market share for exclusive arrangements has created a strong impression that the FTC/DOJ view exclusive dealing arrangements with considerable suspicion. A 20 percent market share threshold is extremely low, and harkens back to the time when atomized markets

[30] In 2002, however, the FTC issued a staff advisory letter to MedSouth, Inc., an IPA based in Denver, Colorado with over 400 physicians.7 And in 2007, the FTC issued a staff advisory letter to the Greater Rochester Independent Practice Association, Inc. (GRIPA), a network based in Rochester, New York with over 600 physician members. Letter from Markus H. Meier to Christi J. Braun & John J. Miles, Sept. 17, 2007 ("GRIPA").
[31] See "N.Y. IPA struggles to land clients," August 23, 2010, Modern Physician.

were the fundamental goal of antitrust policy. Today, market shares in the 30 percent range are routinely deemed too low to support market power claims.

Existing non-exclusive clinical integration programs have not done well commercially, and this includes the non-exclusive networks that have received favorable advisory letters from the FTC. This is not surprising. Structuring a clinical integration program on a non-exclusive basis invites free riding. The hallmarks of a clinical integration program are (a) creating treatment protocols that improve outcomes and lower cost, (b) teaching these protocols to physicians, (c) making sure these protocols are being followed, and (d) creating the infrastructure needed to support the clinical integration efforts, such as HIT systems and interoperability to enable physicians and other clinicians to securely exchange health information about their patients. Developing such a program is expensive and requires both a substantial start-up investment and then continuing investments to maintain the program.

While a clinical integration program makes the delivery of physician services more efficient and generates savings that are passed along to insurers (not physicians), an ACO has to charge insurers for this service to survive. An individual health insurer has significantly less incentive to purchase this enhanced service from the ACO program, if it can sign contracts with individual physicians (whose practices have been advantaged by, for example, HIT training) and get some portion of the benefits created by the clinical integration program at no additional cost. Free riding can happen because physicians cannot practically discriminate between patients coming through the clinical integration program and patients coming through independently negotiated contracts. This is a textbook free ride.

If enough insurers take a free ride, the clinical integration program will fail and all or most of the efficiencies created by the program will be lost at some point. Also, the more likely this outcome, the less likely it becomes that physicians will set up such arrangements in the first place. Physicians, especially those in small practices, understand the overwhelming bargaining power of the major health insurers vis-à-vis small physician practices. They know that if the health insurers are free to cut deals around the ACO they will be successful because no small practice will be willing to decline the health insurers' offer and run the risk of being left out in the cold. Therefore, some physicians will be unlikely to make the initial investment in a clinical integration program in the absence of ACO exclusive dealing.

Exclusive dealing arrangements are a critical tool that ACOs may need to use. This is not a radical or particularly new idea. Joint ventures in other industries routinely engage in exclusive dealing in order to prevent free riding and to align the interests of its members. Courts have recognized that exclusive dealing is both efficiency enhancing and frequently necessary for the efficient operation of a joint venture. It is time for the antitrust enforcement agencies to recognize these points in the case of ACOs.

5. Market power

A full discussion of the issue of market power for ACOs using an exclusive dealing model is beyond the scope of this paper, but the AMA welcomes the opportunity to discuss this issue further. As noted above, AMA believes that ACOs with substantially more than 20% of the market will often be procompetitive. The FTC/DOJ should also recognize that ACOs using a

non-exclusive model will not raise market power concerns, except in the most unique and extreme circumstances.

6. Joint negotiations conducted at the request of the health insurer

The AMA shares the concern expressed by the DOJ that there are strong barriers to entry and expansion in health insurance markets. *See* remarks of Christine A. Varney prepared for the American Bar Association/Antitrust in Healthcare Conference, May 24, 2010. These problems may be ameliorated by the ACA's provisions both for state-based health insurance marketplaces called exchanges and for consumer operated and oriented health plans.

By forming ACOs and jointly contracting, the physician community can offer new health insurance market entrants savings in transaction costs. ACOs can allow a new entrant to directly negotiate with a physician network, making it unnecessary for the new entrant to create its own network or to put in place the administrative structures needed to negotiate hundreds of individual contracts.

Physicians that form a non-exclusive ACO should be confident that if they engage in joint negotiations at the request of the health insurer, a contract rejection cannot be characterized as an antitrust conspiracy. This principle is a matter of common sense; the antitrust laws are a consumer welfare prescription and allow consumers to engage in negotiations they want. Moreover, there is directly supporting case authority. For example, in *Tunica Web Advertising v. Tunica Casino Operators Ass'n, Inc*, 496 F 3d 403 (5th Cir. 2007) the plaintiff had accused a casino trade association and it members of collectively refusing to deal with the plaintiff—a conspiracy in violation of the antitrust laws. The plaintiff, however, had made an offer to the association and its members and requested a joint response to its offer. The Fifth Circuit held that under these circumstances, the joint refusal to accept the offer did not constitute concerted conduct by the casino association and its members under the antitrust laws. The court stated: "Given the joint nature of TWA's initial proposal, which invited the casinos to respond together as a single entity, the casinos' decision to reject that proposal is not concerted action subject to section 1." *Id.* at 410. **Accordingly, the Agencies should adopt the principle that joint negotiations conducted at the request of the health insurer cannot constitute an antitrust conspiracy.**

7. Additional protections that should be considered

Physicians will be discouraged from investing and taking part in new delivery and payment models if the legal protections from civil penalties and criminal sanctions afforded to them could suddenly expire. Therefore any safe harbors, exceptions, exemptions, or waivers allowed under the Shared Savings Program should continue beyond the expiration date of the program so that any organizational structure participating as an ACO does not become illegal overnight simply because the program does not continue.

Finally, advising physicians that ACOs are subject to rule of reason rather than per se analysis, while necessary, may not be sufficient to support physician decisions to invest in ACOs. Physicians may for example, worry that an ACO might raise market power concerns. Networks need scale to participate as ACOs. The ACA itself requires that ACOs have primary care professionals sufficient to treat a beneficiary population of at least 5,000

beneficiaries. In many communities a combination of that scale requirement and the accident of geography (such as a small metropolitan area) would require physician networks to possess large market shares. Although proper interpretation of the antitrust laws is that they are a consumer welfare prescription, a high market share that ultimately benefits consumers by allowing physician networks to serve as ACOs, might nonetheless trigger an antitrust challenge. Accordingly, states should be encouraged to enact laws that treat ACOs in metropolitan areas with small populations or ACOs in rural areas as natural monopolies subject to state regulation and thereby immune from the federal antitrust laws under the state action doctrine.

Conclusion

The AMA applauds the Committee for examining the important issues of health insurer market concentration and antitrust barriers to physician engagement in ACOs. As Congress continues to examine health care delivery, and as we move forward in implementing the ACA, the AMA urges the Committee to be mindful of the vital role that physicians play in patient care. Physicians are critical in efforts to improve quality and to provide coordinated care for patients, and should be supported in these efforts, rather than penalized, by antitrust law and enforcement. We have been encouraged by the FTC and the DOJ's willingness to work with us on these issues, and look forward to working with the Committee to address any questions on our comments.

Mr. COBLE. I thank the Chairman.
Mr. JOHNSON. I thank the gentleman for his statement.

I now recognize John Conyers, a distinguished Member of this Subcommittee and also the distinguished Chairman of the Committee on the Judiciary.

Mr. Chairman.

Mr. CONYERS. Thank you, Chairman Johnson, and Members of the Committee.

I can't tell you how important this hearing is not to just the Committee, but to the whole question of healthcare in terms of the Health Care Reform Act just signed into law and the struggle in America to insure some 50 million people that don't have a dime's worth of insurance, and all that figures into the rising costs of providing healthcare for all Americans.

Bringing in the Department of Justice and the Federal Trade Commission is extremely important because we are in the process of understanding just why there is a disparity between the way doctors are threatened, or hassled, or prosecuted or threatened to be prosecuted and the way, as Mr. Coble said, the health insurance—this is the most powerful group of private corporations in the country, and they don't have any problem coming together to plan for what the rates will be and what the rules will be. Nobody says much about that, to my knowledge. So what this Committee is going to be doing even into the next Congress is getting to understand how come this is so and what can be done to make it come out differently.

Now, maybe somewhere during this hearing today somebody will take issue with my saying that there is a disparity in prosecutorial treatment, and I hope somebody can prove me wrong. But it is pretty obvious doctors, every time they get together, they are always worried about the laws, and what can happen to them, and have they crossed the line or not.

But the insurance companies, how do they operate in real time? Well, not that anybody here doesn't know, but when they set the rates in a region, that is it. You are either in, or you are out. And everybody knows it, especially the doctors and the hospitals. So why didn't they violate antitrust? Well, Chairman, that is just the way it goes. I mean, that is the way it has always been.

As Chairman Johnson has pointed out, these laws, when this first started 30 or 40 years ago, the healthcare insurers were not as large, powerful, or numerous as they are now. We are tracking down some of the merger activities, I think it was in Arizona, where they have exceeding control over the way medicine and healthcare delivery is practiced, and it is that way almost everywhere else.

So we appreciate your witnesses here. I think we have got a great set of panels. And I appreciate what everybody has done.

And since everybody is saying goodbyes and giving out kudos, we are not going out of business, gang. We are just going into a new session, and there is new leadership. I would like to remind my colleague this has happened before and will no doubt happen again.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you, Mr. Chairman.

I can only hope that I can be around for as many years as the Chairman so that I can experience the ebb and flow and ebb again. Thank you. And I am not sad either. I am just reminiscing. Senti-

mentalism, I guess, is eking out. But I am happy for my colleagues on the other side of the aisle.

And I would ask, are there any other Members who wish to make opening statements?

That being the case, other Members' opening statements will be included in the record.

I am now pleased to introduce the witnesses for today's hearing. Today's hearing will feature two panels. On our first panel we have Richard Feinstein, Director of the Bureau of Competition for the Federal Trade Commission.

Welcome back, Mr. Feinstein.

Mr. FEINSTEIN. Thank you, Mr. Chairman.

Mr. JOHNSON. Our second witness is Sharis Pozen. She is Chief of Staff for the Antitrust Division of the Justice Department.

Welcome, Ms. Pozen.

Ms. POZEN. Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you both for your willingness to participate in today's hearing. Without objection, your written statement will be placed into the record, and we ask that you limit your oral remarks to 5 minutes. You will note that we have a lighting system that starts with a green light. At 4 minutes, it turns yellow, then red at 5 minutes. After each witness has presented his or her testimony, Subcommittee Members will be permitted to ask questions subject to the 5-minute rule.

Mr. Feinstein, would you begin, please?

TESTIMONY OF RICHARD FEINSTEIN, DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION, WASHINGTON, DC

Mr. FEINSTEIN. Thank you very much, Mr. Chairman and Ranking Member Coble, Members of the Subcommittee. I am Richard Feinstein, Director of the Bureau of Competition at the FTC. I very much appreciate the opportunity to testify today on behalf of the FTC about the relationship between competition and antitrust enforcement on the one hand and lower healthcare costs and higher healthcare quality on the other hand.

I should note for the record that the prepared written statement submitted for this hearing represents the view of the FTC. My oral statement and answers to any questions today represent my own views and not necessarily those of the Commission or any individual Commissioner.

We are at an important point in the history of providing healthcare in this country.

Mr. JOHNSON. Mr. Feinstein, if I might ask you to pull that microphone a little closer.

Mr. FEINSTEIN. A comprehensive healthcare reform bill has become law. No one can foresee exactly how all the provisions of the new law will mesh with the current system, but we believe a continued effective antitrust enforcement is a necessary component of any plan.

In the Bureau of Competition, protecting and promoting competition in the healthcare sector is a number one priority. We believe that antitrust enforcement improves healthcare in two ways. First, it prevents or stops anticompetitive agreements to raise prices,

thus saving money for consumers. Second, competition spurs innovation that improves care and expands access.

For these reasons, the FTC has a long history of promoting competition in the healthcare sector, broadly defined, of course, to include not only hospitals and physicians, but also pharmaceutical and medical device markets, among others. Just this morning, for example, the Commission announced a case challenging a clinical lab consolidation in southern California which threatens to increase the cost of laboratory services paid for by physician groups.

While the Commission's written prepared statement addresses our merger activity in more detail, this morning I will briefly describe our activities with respect to joint price negotiations by healthcare providers that harm consumers and our efforts to provide guidance on accountable care organizations and clinical integration.

Some have suggested that the antitrust laws act as barriers to healthcare provider collaborations that can lower costs and improve quality. In my view, that is simply wrong. The FTC plainly recognizes that joint conduct among healthcare providers, such as clinical integration, can foster proconsumer innovations in delivery of healthcare services.

Stated simply, what the FTC seeks to prevent are anticompetitive agreements to fix the prices that healthcare providers charge without benefits to patients. Such arrangements typically involve competing providers agreeing to charge the same high prices and collectively refusing to serve the health plan's patients unless their fee demands are met. These agreements are likely to raise prices for the provider's services without improving care, and have routinely been deemed to violate the antitrust laws.

However, we do not want enforcement of the antitrust laws to impede new and potentially more efficient ways of delivering and financing healthcare services. Antitrust standards properly distinguish between price fixing by healthcare providers, which is likely to increase healthcare costs, and effective clinical integration among healthcare providers that has the potential to achieve cost savings and improve health outcomes.

When analyzing these types of collaborations, we ask two basic questions. First, does the proposed collaboration offer the potential for proconsumer cost savings or quality improvements in the provision of healthcare services; and, two, are any price agreements or other agreements among participants regarding the terms on which they will deal with healthcare insurers reasonably necessary to achieve those benefits? If the answer to both of those questions is yes, then the collaboration is analyzed under the rule of reason rather than the per se rule that otherwise applies to pricing agreements among competitors. And as long as the collaboration cannot exercise market power, it is unlikely to raise significant antitrust concerns, because the collaboration has the potential to benefit consumers rather than harm them.

To aid providers considering these types of collaborations, the FTC and the Department of Justice issued statements of antitrust enforcement policy in healthcare that provide guidance about the antitrust analysis that would be applied to various types of healthcare arrangements. The FTC staff also issues detailed advi-

sory opinions as well as routinely issuing informal guidance on specific proposals when requested.

The FTC is actively working on policy questions concerning accountable care organizations, or ACOs, which are encouraged by the new healthcare law to integrate providers in order to increase quality care and decrease costs. Many ACOs that will be set up to serve Medicare patients pursuant to the Affordable Care Act may wish to contract with payers in private healthcare markets as well, which may raise competition issues.

To explore these issues, the FTC, CMS, and the HHS Inspector General's Office hosted a workshop on October 5 to obtain information from industry stakeholders who have an interest in the development and operation of clinically integrated healthcare groups. We will continue to work with other government agencies, including, of course, our colleagues at the Department of Justice, to develop

workable rules and regulations for ACOs.

I have just about 5 more seconds, with your permission.

We want to design rules for ACOs that are flexible enough to allow collaboration in healthcare that will improve quality and decrease costs without creating undue market concentration and price fixing.

Thank you very much for the opportunity to share the FTC's views on these vitally important issues. I, of course, look forward to answering your questions.

Mr. JOHNSON. Thank you, sir.

[The prepared statement of Mr. Feinstein follows:]

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

PREPARED STATEMENT OF THE
FEDERAL TRADE COMMISSION

Before the

COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON COURTS AND COMPETITION POLICY

On

Antitrust Enforcement in the Health Care Industry

December 1, 2010

I. Introduction

Chairman Johnson, Ranking Member Coble, and members of the Subcommittee, I am Richard A. Feinstein, Director of the Bureau of Competition at the Federal Trade Commission (FTC). I appreciate the opportunity to testify on behalf of the Commission about the relationship between competition and antitrust enforcement, on the one hand, and lower health care costs and higher health care quality, on the other.[1] The magnitude of health care costs and the importance of health care quality demand our urgent attention. On a daily basis, millions of Americans require health care goods and services to maintain their basic quality of life. We have all seen the stories about the nearly 50 million uninsured,[2] and the fact that the U.S. health care system spends more per person, yet generates lower health care quality, than health care services in many other developed countries.[3] Health care costs burden both employees and employers, large and small, as well as federal, state, and local governments that pay for care under various government programs.

We are at an important point in the history of providing health care in this country. A comprehensive health care reform bill has become law.[4] No one can foresee exactly how all the provisions of the new law will mesh with the current system. But we can be certain that all stakeholders will have a part to play in making the new system run

[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and responses are my own and do not necessarily reflect the views of the Commission or of any Commissioner.
[2] *See* U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, 19-20 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf (noting slight decrease from 2006-07, but a general increase in uninsured from 1987-2007).
[3] *See, e.g.*, The Business Roundtable, The Business Roundtable Health Care Value Comparability Study, Executive Summary at 2 (2009), *available at* http://s73976.grindserver.com/healthcarestudy.pdf (observing 23 percent "value gap" relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France).
[4] The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119-1025 (March 23, 2010), to be codified at scattered sections of 42 U.S.C. ("Affordable Care Act"), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (March 30, 2010).

as efficiently as possible, so that the best health care can be provided to the most consumers at the least cost. Congress has charged the FTC with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] The FTC has played, and will continue to play, an important role in protecting and promoting competition to lower costs and improve quality, and believes that continued effective antitrust enforcement is a necessary component of any plan to improve health care.

Antitrust enforcement can improve health care in two ways. First, by preventing or stopping anticompetitive agreements to raise prices, antitrust enforcement saves money that consumers, employers, and governments otherwise would spend on health care. Second, competition spurs innovation that improves care and expands access.

The Commission tries to leverage its limited resources to yield the greatest benefit for American consumers. For example, the Commission has made stopping pay-for-delay agreements a top priority because of the substantial harm to consumers from these deals: a recent FTC Staff study found that they cost consumers about $3.5 billion a year.[6] On the merger front, the Commission has challenged numerous pharmaceutical acquisitions to prevent price increases and promote innovation. Last year the Commission successfully blocked CSL's attempt to acquire its competitor Talecris, preventing anticipated price increases in the multi-billion dollar blood plasma market.[7] Although pharmaceutical matters demand substantial resources and raise complex issues, the Commission pursues them because of the importance of pharmaceutical competition.

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[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] FEDERAL TRADE COMMISSION, PAY-FOR-DELAY: HOW DRUG COMPANY PAY-OFFS COST CONSUMERS BILLIONS (Jan. 2010), *available at* http://www.ftc.gov/os/2010/01/100112payfordelayrpt.pdf.

[7] Fed. Trade Comm'n v. CSL Ltd. and Cerberus-Plasma Holdings LLC, 09-cv-1000-CKK (D. D.C. 2009) (Complaint).

The Commission has also stopped the accumulation of market power among hospitals and other clinics that threatened to increase prices or reduce quality, such as in the proposed merger of Inova Health System and Prince William Hospital in northern Virginia. After the Commission sued to enjoin the merger in federal district court, the parties decided to drop the deal.[8]

The Commission's enforcement efforts in the healthcare arena are also focused on protecting incentives to innovate. For example, Thoratec, the only producer of blood pumps used to support and sustain patients suffering from end-stage heart failure, sought to acquire Heartware, a potential entrant which was seeking approval for a new and innovative product. In 2009, the Commission successfully challenged this transaction to protect the vibrant competition between these two companies to innovate and develop new products that will improve health care.[9]

The FTC has also continued to challenge anticompetitive agreements among health care providers to fix the prices they charge to health insurance plans, conduct likely to raise prices without improving quality of care or expanding access to care.[10] The Commission's enforcement efforts also have helped assure that new and potentially more efficient ways of delivering and financing health care services can develop and compete in the marketplace.[11]

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[8] *See infra* note 18 and accompanying text.
[9] *In the Matter of Thoratec Corp. and HeartWare Int'l, Inc.*, FTC Dkt. No. 9339 (July 30, 2009) (Complaint), *available at* http://www.ftc.gov/os/adjpro/d9339/090730thoratecadmincmpt.pdf.
[10] *See* Fed. Trade Comm'n, FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *available at* http://www.ftc.gov/bc/healthcare/antitrust.pdf.
[11] *See id.*

Finally, the FTC and its staff have issued studies and reports regarding various aspects of the health care industry[12] and have analyzed competition issues raised by proposed state and federal regulation of health care markets.[13]

Based on the Subcommittee's interest, the Commission's testimony today will describe how our activities in two areas – (1) proposed mergers involving hospitals and outpatient clinics and (2) joint price negotiations by health care providers – further the goals of reducing costs and improving quality in the delivery of health care.[14] The testimony will also discuss Accountable Care Organizations ("ACOs"), and the Commission's efforts to provide guidance to ACOs as they develop in the marketplace. It is important to note, however, that these areas, as important as they are, do not represent the sole or even the bulk of the Commission's broad set of enforcement activities to protect American consumers from anticompetitive activity in health care markets.

II. Increased Merger Scrutiny

A growing body of literature suggests that providers with significant market power can negotiate higher-than-competitive payment rates.[15] The Commission has

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[12] *See, e.g.*, FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf; FED. TRADE COMM'N, THE STRENGTH OF COMPETITION IN THE SALE OF CONTACT LENSES: AN FTC STUDY (2005), *available at* http://www.ftc.gov/reports/contactlens/050214contactlensrpt.pdf; FED. TRADE COMM'N AND DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[13] *See e.g.*,Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. on the Judiciary, Concerning H.R. 971, "the Community Pharmacy Fairness Act of 2007," 110th Cong. (Oct. 18, 2007), *available at* http://www.ftc.gov/os/testimony/P859910pharm.pdf (criticizing proposal to exempt non-publicly traded pharmacies from antitrust scrutiny).

[14] On multiple occasions, the Commission has provided Congress testimony on the dangers of pay-for-delay patent settlements between brand and generic companies and the costs they impose on consumers, employers, and the government. Today, the Commission is providing testimony on other important areas of health care competition.

[15] *See, e.g.*, Ginsburg, Paul B., *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Center for Studying Health System Change, Research Paper No. 16, Nov. 2010,

worked to preserve competition in health care markets, in part, by carefully scrutinizing mergers and acquisitions by providers.

Several recent hospital merger enforcement actions highlight the Commission's ongoing focus on competition among hospitals. If a hospital acquisition deprives patients of choices for health care, it can increase the health care costs to both patients and employers that purchase health insurance. For example, in 2007, the Commission ruled that Evanston Northwestern Healthcare's consummated acquisition of its competitor, Highland Park Hospital, was anticompetitive[16] because the acquisition resulted in substantially higher prices and a substantial lessening of competition for acute care inpatient hospital services in parts of Chicago's northern suburbs.[17] Evanston's acquisition of Highland Park underscores the dangers that the accumulation of market power poses for consumers, the government, and employers, all of whom pay for health care.

A 2008 joint enforcement action by the FTC and the Virginia Attorney General stopped a merger of two health systems in northern Virginia that, according to the complaint, would have resulted in control of 73 percent of the licensed hospital beds in the area.[18] In our most recent merger case, the Commission challenged an acquisition that would have combined the two largest providers of acute inpatient psychiatric

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available at www.hschange.org/CONTENT/1162; Berenson, R., Ginsburg, P., & Kemper, N., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS No. 4 (April 2010).

[16] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Dkt. No. 9315 (Aug. 6, 2007) (Opinion of the Commission), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf (upholding with some modifications an October 2005 Initial Decision by an FTC Administrative Law Judge).

[17] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Dkt. No. 9315 (Oct. 20, 2005) (initial decision), *available at* http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf.

[18] *See In the Matter of Inova Health System Foundation and Prince William Health Systems, Inc.*, FTC Dkt. No. 9326 (Jun. 17, 2008) (Order dismissing complaint), *available at* http://www.ftc.gov/os/adjpro/d9326/080617orderdismisscmpt.pdf.

services in each of three markets – Delaware, Puerto Rico, and metropolitan Las Vegas.[19] The settlement preserves competition in the relevant areas by requiring the sale of 15 facilities to FTC-approved buyers. In all of these instances, the Commission acted to protect consumers and competition.

III. Physician Services: Price Fixing vs. Clinical Integration

Some have suggested that the antitrust laws act as barriers to health care provider collaborations that could lower costs and improve quality.[20] That is simply wrong. Antitrust standards distinguish between price fixing by health care providers, which is likely to increase health care costs, and effective clinical integration among health care providers that has the potential to achieve cost savings and improve health outcomes. In order to assist in making that distinction clear, the Commission has provided extensive guidance on how health care providers can collaborate in ways consistent with the antitrust laws, precisely because such collaborations have the potential to reduce costs and improve quality.

A. Price Fixing and Group Boycotts Are Likely to Raise Prices and Harm Consumers.

For more than 25 years, the Commission has challenged price fixing and boycott agreements through which health care providers jointly seek to increase the fees that they

[19] *In the Matter of Universal Health Services, Inc.*, FTC Dkt. No. C-4308 (consent order) (Nov. 15, 2010), *available at* http://www.ftc.gov/os/caselist/1010142/101115uhspsido.pdf.

[20] *See, e.g.*, Letter from Michael D. Maves, MD, Exec. Vice President, CEO, American Medical Ass'n, to the Hon. William E. Kovacic, Chairman, Federal Trade Commission, regarding Physician Network Integration and Joint Contracting (June 20, 2008), *available at* http://www.ftc.gov/bc/healthcare/checkup/pdf/AMAComments.pdf ("We are extremely concerned with what we see as the significant regulatory barriers that restrict physicians' ability to collaborate in ways crucial to improving quality and containing costs"); *cf.* Timothy Stolzfus Jost and Ezekiel J. Emmanuel, *Commentary: Legal Reforms Necessary to Promote Delivery System Innovation*, 299 JAMA 2561, 2562 (2008) (suggesting that uncertainty about forms of clinical integration permitted under the antitrust laws "could deter attempts to create accountable health systems.")

receive from health care plans.[21] Such arrangements typically involve competing health care providers agreeing to charge the same high prices and collectively refusing to serve a health plan's patients unless the health plan meets their fee demands. Since its 1982 *Maricopa* decision,[22] the U.S. Supreme Court has held that such conduct is considered to be *per se* unlawful because it is so likely to harm competition and consumers by raising prices for health care services and health care insurance coverage. This remains good law, and is also good competition policy. As part of its mission, the Commission continues to investigate such conduct.

The Commission's cases have challenged groups of providers that simply seek to jointly negotiate the fees they receive without improving quality, coordinating the care they provide, or reducing health care costs. The U.S. Court of Appeals for the Fifth Circuit recently affirmed a Commission opinion finding that an association of independent physicians in the Fort Worth area engaged in horizontal price fixing that was not related to any procompetitive efficiencies.[23] This type of conduct is likely to increase health care costs.

B. The Antitrust Laws Promote Health Care Collaborations that Can Reduce Costs and Improve Quality.

The antitrust laws treat collaborations among health care providers that are *bona fide* efforts to create legitimate, efficiency-enhancing joint ventures differently from the way they treat price fixing schemes. The Commission asks two basic questions with respect to such collaborations. First, does the proposed collaboration offer the potential

[21] *See* FTC Bureau of Competition, Overview of FTC Antitrust Actions in Health Care Services and Products, *available at* http://www.ftc.gov/bc/0608hcupdate.pdf.
[22] *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 356-57 (1982) (agreements among competing physicians regarding fees they would charge health insurers for their services constituted *per se* unlawful horizontal price fixing).
[23] *North Texas Specialty Physicians v. Fed. Trade Comm'n*,528 F.3d 352 (5th Cir. 2008).

for pro-consumer cost savings or quality improvements in the provision of health care services? Second, are any price or other agreements among participants regarding the terms on which they will deal with health care insurers reasonably necessary to achieve those benefits? If the answer to both of those questions is "yes," then the collaboration is not considered a *per se* illegal agreement, but rather is evaluated under a rule of reason standard, which takes into account any likely procompetitive or anticompetitive effects from the collaboration.[24]

The FTC and the U.S. Department of Justice Antitrust Division issued Health Care Statements in 1993, and supplemented them in 1994 and 1996,[25] to provide guidance about what type of antitrust analysis the agencies will apply to various types of health care arrangements. Statement 8 explains how *bona fide* clinical integration by health care providers with the potential for significant cost savings and quality improvements may be demonstrated,[26] and in recent years, FTC staff have issued detailed advisory opinions responding to providers' proposed programs to help inform the industry about how the antitrust laws evaluate such agreements.[27] Proposed collaborations have often used programs such as electronic health records[28] and clinical

[24] *See Maricopa County Medical Soc.*, *supra* note 14, at 343 ("since Standard Oil Co. of New Jersey v. United States, 221 U.S. 1 (1911), we have analyzed most restraints under the so-called 'rule of reason.' As its name suggests, the rule of reason requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition.")

[25] U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm [hereinafter *Health Care Statements*].

[26] *Health Care Statements* at Statement 8, § B.1.

[27] *See, e.g.*, Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun, Ober, Kaler, Grimes & Shriver 8 (April 13, 2009) [hereinafter TriState Letter], *available at* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf; Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun & John J. Miles, Ober, Kaler, Grimes & Shriver 7 (Sept. 17, 2007) [hereinafter GRIPA letter], *available at* http://www.ftc.gov/bc/adops/gripa.pdf.

[28] Clinical integration programs frequently use sophisticated health information technology ("HIT") systems to help them implement their programs. However, the use of HIT systems or electronic health records alone is not sufficient to establish that a group has clinically integrated. It is how the collaboration uses those tools that counts for the antitrust analysis.

support for care management and quality improvement as means to achieve efficiencies and improved quality. These arrangements often involve collaboration among clinicians to create guidelines, measure their performance in relation to those guidelines, and agree on remedial approaches and consequences for failures to achieve certain performance goals. These are the same types of measures proposed by advocates of health care reform as ways to reduce costs and improve quality.[29]

IV. Accountable Care Organizations

The new health care law encourages providers to create integrated health care delivery systems that can improve the quality of health care services and lower health care costs. In particular, Section 3022 of the Affordable Care Act establishes a Shared Savings Program to promote the formation of Accountable Care Organizations (ACOs).[30] An ACO can share in savings it creates for Medicare if the ACO meets certain quality performance standards, which are to be established by the HHS Secretary. Although there are several definitions of ACOs, the Congressional Research Service has explained the essential elements as:

> ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others around the ability to receive shared-savings bonuses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.[31]

The basic goal is for ACOs to improve the quality, and lower the costs, of health care by providing coordinated – rather than fragmented – care to patients. For example, an ACO

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[29] Elliot S. Fisher et al., *Achieving Health Care Reform – How Physicians Can Help*, 360 NEW ENG. J. MED. 2495, 2496 (2009); *see also, e.g.*, TriState Letter, *supra* note 18 (discussing web-based HIT system, software, and clinical guidelines and review proposal); GRIPA Letter *supra* note 18 (regarding GRIPA's tablet computer, HIT system, and data sharing proposal).

[30] Affordable Care Act, 42 U.S.C. § 3022.

[31] Congressional Research Service, "Accountable Care Organizations and the Medicare Shared Savings Program," (Nov. 4, 2010), at 1, *available at* http://op.bna.com/hl.nsf/id/bbrk-8b2tvz/$File/CRSACO2010november.pdf.

can ensure that a particular patient with multiple chronic conditions is treated by ACO doctors that all have access to the same patient medical records, work together to plan the appropriate courses of treatment, and manage the patient's care to avoid harmful pharmaceutical interactions.

Experience has shown that integrating health care delivery among independent providers is a complex process that requires a substantial commitment of health care providers' resources and time.[32] Recent commentary suggests that, because of the resources and time required to integrate independent provider practices, health care providers are more likely to integrate their care delivery for Medicare beneficiaries if they also can use the same delivery system for patients covered by health care insurance in the private market. Thus, antitrust guidance may be appropriate for ACOs operating both under the Shared Savings Program and in the private market.

The FTC is using its experience and expertise in enforcing the antitrust laws in health care markets to work with other agencies, including the Department of Justice ("DOJ"), the Centers for Medicare & Medicaid Services ("CMS"), and the Office of the Inspector General ("OIG") of the Department of Health and Human Services, to develop workable rules and guidance for such ACOs.

To learn as much as possible about how well integrated health care delivery systems are currently operating, and to understand better how providers plan to integrate and participate in the Shared Savings Program, the FTC, CMS, and OIG hosted a workshop on October 5, 2010. The workshop was designed to obtain information from industry stakeholders who have an interest in, or experience with, the development and

[32] *See* Stephen M. Shortell, Lawrence P. Casalino, Elliott Fisher, "Implementing Accountable Care Organizations," Policy Brief (May 2010), *available at* http://www.law.berkeley.edu/files/chefs/Implementing_ACOs_May_2010.pdf.

operation of clinically or financially integrated health care groups. Participants included health care providers with integration efforts planned and underway, payers (insurers, employers, and consumers), and experts in health care policy. We learned a great deal from the workshop participants and from those who submitted comments in connection with the workshop, and that learning informs our consideration of possible policy approaches to ACOs.

As Chairman Leibowitz explained in opening the workshop, we want to explore whether we can develop safe harbors for ACOs, and whether it may be possible to have an expedited review process for those ACOs that fall outside of the safe harbors.[33] Commission staff is discussing those issues in depth with our colleagues at the Antitrust Division. Staff has received comments suggesting other approaches as well.[34] We believe antitrust policy can support the improved health care services and lower health care costs that Congress sought through the Shared Savings Program; after all, the antitrust laws do not stand in the way of collaborations among providers that improve health care quality and lower costs.

At the same time, it would be a mistake to ignore the lessons of the last quarter century. Simply allowing providers to fix prices or to accumulate market power will increase health care costs and frustrate the national imperative to control health costs, a goal that we all share. As Chairman Leibowitz noted at the workshop:

> So, the question before us today is: How can we design rules for ACOs that are flexible enough to allow the health care community to collaborate

[33] Jon Leibowitz, Chairman, Federal Trade Commission, Remarks Before the Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty Laws at 1 (Oct. 5, 2010) *available at* www.ftc.gov/opp/workshops/aco/docs/leibowitz-remarks.pdf (hereinafter, "Leibowitz Remarks").

[34] *E.g.*, Comments of Blue Shield of California, *available at* www.ftc.gov/0s/comments/aco/101104bsc.pdf (suggesting ACOs should not be permitted to engage in certain practices with alleged anticompetitive effects).

> to improve quality and decrease costs – but not to fix prices or create market concentration?[35]

The Commission will continue to work with DOJ, CMS and OIG, and will continue to solicit ideas from those who have a stake in the establishment of an optimum enforcement regime. Of course, that includes all of us – providers, enforcers, and most of all, consumers.

V. Conclusion

Thank you for this opportunity to share the Commission's views on these vitally important issues. The Commission looks forward to working with the Committee to ensure that competitive health care markets deliver on the promise of competitively priced health care goods and services and increased innovation and quality.

[35] Leibowitz Remarks at 3.

Mr. JOHNSON. Ms. Pozen.

TESTIMONY OF SHARIS A. POZEN, CHIEF OF STAFF AND COUNSEL TO THE ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Ms. POZEN. Mr. Chairman, Members of the Subcommittee, I am pleased to be here today to talk about competition policy and antitrust enforcement in healthcare. I will focus on two areas: first, the Antitrust Division's role in ensuring that coordination and integration among healthcare providers encourages innovation and efficiency without harming competition; second, the importance of measured and responsible antitrust enforcement in the health insurance market. Healthcare reform brings both areas to the forefront of competition policy.

The Affordable Care Act allows for the creation of accountable care organizations which, will provide integrated, more efficient, higher-quality delivery and payment for Medicare and Medicaid services and their beneficiaries. The act also establishes competitive marketplaces and exchanges where individuals and small employers can purchase health insurance. The success of exchanges in ACOs will depend in part on effective competition both among health insurers and providers.

Moreover, clear and accessible antitrust guidance will contribute to the success of these organizations. The Department is committed to providing efficient, quick review of any new business model that plans to deliver integrated care.

ACOs are a good example of how providers might work together to deliver more efficient, high-quality care without inhibiting competition. ACOs are made up of providers that coordinate care for Medicaid beneficiaries with a common set of care protocols utilizing health ITs, investing in infrastructure, and meeting quality targets. If the ACO meets quality of care and cost targets, the ACO then shares those savings with the public through reduced governmental expenditures.

The Department is actively working with the Health and Human Services and the Federal Trade Commission as the ACO regulatory process evolves, and the Department intends to offer whatever guidance and clarity may be needed to ensure that ACOs do not run afoul of the antitrust laws. The Department will provide expedited antitrust review to any ACO requesting our assistance.

The Antitrust Division continues to undertake responsible and measured enforcement to prevent

anticompetitive behavior in the healthcare industry. This enforcement is driven by the Division's analysis of evolving market forces, structures, and dynamics in the healthcare industry. For example, the Department recently reviewed and analyzed evidence that demonstrated that entry and expansion in the healthcare industry faces strong barriers. This conclusion is significant, given that the Affordable Care Act provides the opportunity to reduce these barriers through newly formed health insurance exchanges, which again offer individuals and small businesses more affordable health insurance options.

The difficulty of successful entry makes it even more important to preserve the choices already available, particularly as the ex-

changes are formed. Therefore, the Department of Justice will carefully review and challenge mergers that are likely to substantially lessen competition in the health insurance industry. The Justice Department will carefully scrutinize and continue to challenge exclusionary practices by dominant firms, whether for-profit or nonprofit, that substantially increase the cost of entry or expansion.

For example, the Division recently filed a civil antitrust lawsuit against Blue Cross Blue Shield of Michigan, joined by the State of Michigan, alleging that Blue Cross used its dominance to impose anticompetitive most favored nations provisions in its agreements with approximately half of Michigan's general acute-care hospitals; approximately 70 hospitals. The Blue Cross MFNs require a hospital either to charge Blue Cross no more than it charges Blue Cross' competitors or to charge the competitors up to 40 percent more than it charges Blue Cross. These MFNs raise hospital prices, prevent other insurers from entering the marketplace, and discourage discounts, which inflate the cost of healthcare services and insurance.

This action is significant for Michigan, but it has broader implications. Any time a dominant provider uses

anticompetitive agreements, the market suffers. This cannot be allowed in Michigan or anywhere else in the United States. American consumers deserve affordable healthcare and competitive prices, and the Antitrust Division will vigorously pursue agreements and transactions that stand in the way of achieving this goal.

Enforcement actions such as the Division's lawsuit against Blue Cross work hand in hand with our efforts to prevent illegal consolidation in the health insurance market. In March, the Division informed the Blue Cross and Physician Health Plan of Mid-Michigan, the two largest providers of commercial health insurance in Lansing and their most significant rivals, that it would challenge their plans to merge. The companies abandoned the transaction. That transaction would have resulted in substantial lessening of competition in the Lansing market for commercial group health insurance and in the market for the purchase of physician services.

In closing, the Justice Department believes that antitrust has and will continue to play an essential role in healthcare. To achieve the goals of healthcare reform, we must ensure that are our healthcare markets are as competitive as possible. This requires more than business as usual. We must provide predictability through clear and accessible guidance to healthcare consumers, providers, and payers. And the Antitrust Division is up to this task.

Thank you.

Mr. JOHNSON. Thank you, Ms. Pozen.

[The prepared statement of Ms. Pozen follows:]

PREPARED STATEMENT OF SHARIS A. POZEN

Department of Justice

STATEMENT

OF

SHARIS A. POZEN
CHIEF OF STAFF
ANTITRUST DIVISION

BEFORE THE

SUBCOMMITTEE ON COURTS AND COMPETITION POLICY
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY"

PRESENTED ON

DECEMBER 1, 2010

STATEMENT
OF
SHARIS A. POZEN
CHIEF OF STAFF
ANTITRUST DIVISION
BEFORE THE
SUBCOMMITTEE ON THE COURTS AND COMPETITION POLICY
COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES
CONCERNING
ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY
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Mr. Chairman and members of the Subcommittee, I am pleased to speak to you today about the importance of antitrust enforcement and competition policy in health care. Our health care system is undergoing significant reform designed to bring more affordable insurance and more affordable care to American consumers. The Department of Justice generally, and the Antitrust Division specifically, has a substantial role to play to ensure that America's consumers benefit fully from health care reform designed to maintain strong, competitive health care markets. The Patient Protection and Affordable Care Act, signed into law on March 23, and the Health Care and Education Reconciliation Act of 2010, signed into law on March 30 (collectively known as the Affordable Care Act) rely, in part, on the principle that robust competition will expand coverage and increase consumer choices while containing cost. To be sure, implementing this vision will involve an unprecedented effort for federal and state regulators. Yet, like many reforms, the success of these legislative and regulatory efforts will depend as much upon healthy competitive markets free from undue concentration

and anticompetitive behavior as it will upon regulatory change. In short, the recent health care reforms make effective antitrust policy more important than ever.

When we discuss health care and antitrust, McCarran-Ferguson often enters the discussion, and it will here. The Department supports efforts to bring more competition to the health insurance marketplace that lowers costs, expands choice, and improves quality. In February, the House voted overwhelmingly, 406 to 19, in passing the Health Insurance Industry Fair Competition Act (H.R. 4626), to amend the McCarran-Ferguson Act to provide that nothing in the Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance. This Subcommittee's invaluable work—including its October 2009 hearing, for which the Antitrust Division provided testimony and other materials for the record—has been important. The Administration's Statement of Policy, strongly supporting the Health Insurance Industry Fair Competition Act, noted that health care reform should be built on a strong commitment to competition in all health care markets, including health insurance. (The Statement is available at *www.whitehouse.gov/sites/default/files/omb/legislative/sap/111/saphr4626r_20100223.pdf*.) The passage of the Health Insurance Industry Fair Competition Act, as it applies to the health insurance industry, would give American families and businesses, big and small, more control over their own health care choices by promoting greater insurance competition and outlawing anticompetitive practices like price fixing, bid rigging, and market allocation that drive up costs for all Americans.

As I am sure the Subcommittee is aware, the United States spends an exceptionally high amount on health care. In 2009, U.S. health care expenditures were

projected to be over 17 percent of GDP—or about $2.5 trillion—accounting for 1/6th of the U.S. economy. *See* Christopher J. Truffer et al., *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFFAIRS 1 (March 2010). Such a large "part of the trade or commerce among the several states," to use the words of the Sherman Act, would make health care a vitally important sector for antitrust enforcers even if there had been no health care reform. The Affordable Care Act, and the prospect of expanded consumer choice, only increases this importance.

Today, I would like to focus my remarks on two areas. The first area I would like to address is the importance of encouraging innovation and efficiency in health care delivery and the ways in which coordination and integration among health care providers can help achieve these goals while still preserving competitive markets. The second is the importance of measured, responsible antitrust enforcement in preserving open and vigorous competition in health insurance markets. In that regard, I will touch on our recent enforcement actions as well as our effort to improve our knowledge base in this important industry. In an area as dynamic as modern health care, it is essential to engage in frequent, in-depth review and reassessment, and the Antitrust Division has been doing just that over the past few months as part of our enforcement efforts.

Both of these initiatives are even more important with the advent of health care reform. Two significant aspects of the Affordable Care Act are the establishment of new competitive marketplaces—known as Exchanges—for individuals and small employers to purchase health insurance, and the formation of Accountable Care Organizations (ACOs) and other initiatives to provide for more efficient, higher quality delivery of Medicare and Medicaid services, and ultimately to benefit private pay patients as well.

The success of the Exchanges and the ACOs will depend, in part, on effective competition, both among health care insurers and providers. Moreover, clear and accessible guidance on antitrust issues associated with both can contribute to their success. The Department is committed to providing efficient, time-limited review to any new business models that meet clearly defined clinical integration standards.

The Affordable Care Act was enacted in order to expand coverage, improve quality, and lower the cost of health care for all Americans. The role of antitrust is to ensure that competition is preserved and protected to help reach this goal. The Antitrust Division is committed to fulfilling its part of the indispensible role that antitrust has in improving our nation's health care system.

Innovation and Efficiency in Health Care Delivery

There can be no doubt that vigorous yet responsible antitrust enforcement is crucial if we are to benefit from innovation and efficiency in our health care delivery system and reduce rising health care costs in both the public and private sectors.

The U.S. population is aging, with the baby boomers once again transforming the demographic landscape as they reach 65. These changing demographics demand that we devise ways to treat even greater numbers of increasingly sick patients more efficiently and effectively. Unquestionably, that will lead to additional interest in integrating what is now a fragmented health care delivery system.

There does not seem to be serious dispute that more integration and coordination in delivery of health care services have the potential to decrease costs and improve

quality. The key is whether we can gain those benefits without sacrificing meaningful competition.

The answer to that question is undoubtedly yes. The Health Care Policy Statements and business reviews of the federal antitrust enforcement agencies make clear that antitrust is not an impediment to the formation of innovative, integrated health care delivery systems and genuine increases in provider efficiency. *See* Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, Statement 8 (1996), available at *www.justice.gov/atr/public/guidelines/1791.pdf*. There are many ways under the federal antitrust laws for providers to form joint ventures to control costs and improve quality without unduly inhibiting competition. They can financially integrate, or they can clinically integrate, or, indeed, they can do both. As Assistant Attorney General Christine Varney said in 1996 while serving as a Commissioner at the Federal Trade Commission, the federal antitrust enforcement agencies should be receptive to new and innovative forms of provider arrangements that do not necessarily involve financial risk sharing. *See* Separate Statement of Commissioner Christine A. Varney on the Revised Health Care Guidelines (Aug. 1996), available at *www.ftc.gov/bc/healthcare/industryguide/policy/varney.htm*. As the Policy Statements emphasize, antitrust's ultimate objective is that there be sufficient network integration—whatever that integration may be—for the network to achieve significant, material efficiencies that will benefit consumers.

The Policy Statements discuss what can constitute sufficient clinical integration. They note the role, and import, of establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of

care; selectively choosing network providers who are likely to further these efficiency objectives; and making significant investments in network infrastructure and capability so as to realize these claimed efficiencies.

Our colleagues at the Federal Trade Commission have applied this analysis in a number of advisory opinions involving questions of clinical integration. The advisory opinions confirm that the touchstone of clinical integration analysis is the adoption of a comprehensive, coordinated program of care management designed, and likely, to improve quality and cost-effective care. For example, indicia of clinical integration may include: adequate infrastructure; an adequate number of meaningful protocols for diagnoses and treatment of diseases; enforceable performance standards; and proof of physician commitment to the program. Only that kind of program—with its emphasis on realizing benefits for consumers—justifies rule-of-reason treatment for price setting or other agreements that might otherwise be per se illegal.

The Policy Statements also provide numerous examples of sufficient financial integration. There can be, among other things, an agreement to provide services at a capitated rate, or to provide particular services for a predetermined percentage of the premium or a predetermined revenue stream. There also could be, for instance, the use of significant financial incentives to achieve specific cost-containment goals, or the agreement to treat complex cases for a fixed, predetermined fee. The point is that, however it is to be achieved, it is incumbent upon the group to share financial risk in such a way that each member has an economic incentive to ensure that the group as a whole produces material efficiencies that will benefit consumers.

It is important to keep in mind that not all provider networks involve sufficient financial, clinical, or other economic integration to apply the rule of reason to joint price negotiations with payers. For example, an arrangement among competing providers simply to engage in joint billing, joint collection services, or even joint purchasing of medical supplies or services is generally not the type of economic integration needed to allow providers jointly to set their reimbursement rates under the rule of reason. Rather, such steps simply reflect an effort to coordinate and share some administrative expenses or to receive volume purchasing discounts.

The economic integration that justifies application of the rule of reason to joint price negotiations with payers requires the sharing of some form of financial risk or sufficient clinical integration to induce the group's members to improve the quality and efficiency of the care they provide. While there is no particular formula that can cover all types of legitimate clinical integration, the key is that there must be sufficient clinical integration to motivate the kinds of changes that can achieve real cost-containment or other performance benchmarks. However, where purported efforts to integrate are principally a vehicle for obtaining and exploiting market power or simply a subterfuge for price fixing, then antitrust is there, as it should be, to protect competition and consumers.

The Affordable Care Act's development of ACOs is a good example of how providers might work together to deliver more efficient, high-quality care without inhibiting competition, so long as their collaborations are properly constructed. For example, the ACO can encourage competing physicians, and possibly other providers, to coordinate care for Medicare beneficiaries by redesigning care protocols, utilizing health

IT, investing in infrastructure, and meeting quality targets. If the ACO meets quality-of-care and cost targets, the ACO then shares those savings with HHS.

Properly constructed, ACOs have the potential to improve health care delivery and drive down costs. The antitrust agencies are working together to ensure that ACOs can move forward to provide innovative, higher quality, lower cost delivery of healthcare services, while also ensuring that ACOs are not inhibiting competition. The Department is actively working with HHS and the FTC as the ACO regulatory process evolves to provide clear and practicable guidance for providers to form innovative, integrated health care delivery systems without unduly confining providers to any particular delivery model.

The issue for the ACOs is how to move forward with these delivery models and have some assurance that they will not be subject to antitrust challenge. The Department believes that antitrust should not be an impediment to legitimate clinical integration and is focused on addressing the concerns of those contemplating the formation of beneficial ACOs. The Department intends to offer whatever guidance and clarity may be needed to ensure that providers pursue beneficial integrated ACOs without running afoul of the antitrust laws and to provide an opportunity for ACOs that may exceed a clearly defined antitrust "safe harbor" to obtain efficient, expedited antitrust review.

Enforcement

Vigorous but responsible antitrust enforcement has long been, and will continue to be, crucial to the health care industry. This includes enforcement with respect to

health insurance plans, providers, and others in the industry. The goals of health care reform can more easily be achieved if competition between significant insurers in a particular market is maintained; we must also prevent dominant insurers from using exclusionary practices to blockade entry or expansion by alternative insurers. The same is true if health care providers use supposedly quality-improving or cost-reducing measures simply to raise prices. Thus, the Antitrust Division has undertaken, and will continue to undertake, measured enforcement to prevent such anticompetitive behavior. Let me give you a recent example.

In October, the Division filed a civil antitrust lawsuit against Blue Cross Blue Shield of Michigan (BCBSM) alleging that it has used its dominance to impose anti-competitive provisions in its agreements with approximately half of Michigan's general acute care hospitals. The Division believes that these provisions raise hospital prices, prevent other insurers from entering the marketplace, and discourage discounts, inflating the cost of health care services and insurance.

The challenged provisions are known as most favored nation (MFN) clauses. In the healthcare context, MFN provisions generally refer to contractual clauses between health insurance plans (buyers) and healthcare providers (sellers) that essentially guarantee that no other plan can obtain a better rate than the plan wielding the MFN. Some of the MFNs in this case guarantee the plan an even better rate than given to any other plan or purchaser. The MFNs require a hospital either to charge BCBSM no more than it charges BCBSM's competitors, or to charge the competitors a specified percentage more than it charges BCBSM, in some cases between 30 and 40 percent more. The complaint alleges that BCBSM's use of MFN provisions has reduced competition in the

sale of health insurance in Michigan by raising hospital costs to BCBSM's competitors, which discourages other health insurers from entering into or expanding within markets throughout Michigan. The complaint further alleges that BCBSM agreed to raise the prices that it pays certain hospitals to obtain the MFNs, thus buying protection from competition by increasing its own costs. Importantly, Blue Cross has not sought or used MFNs to lower its own cost of obtaining hospital services.

This action is significant for Michigan, but it is also significant more broadly. These kinds of anticompetitive MFNs affect health care delivery and costs in a very fundamental way. Any time a dominant provider uses anticompetitive agreements, the market suffers. This cannot be allowed in Michigan or anywhere else in the United States. American consumers deserve affordable health care and competitive prices, and the Antitrust Division will vigorously pursue agreements and transactions that stand in the way of achieving this goal. The State of Michigan is also playing a key role in the BCBSM case, and the Division hopes that State vigilance and enforcement will continue to supplement the Division's efforts.

Enforcement actions such as the Division's lawsuit against BCBSM work hand in hand with our efforts to prevent illegal consolidation in health insurance markets. Thus, in March, the Division informed BCBSM and Physicians Health Plan of Mid-Michigan (PHP) that the Division would challenge their plans to merge, leading the companies to abandon the proposed transaction. (The Department's press release is available at *www.justice.gov/atr/public/press_releases/2010/256259.pdf*.) The companies were the two largest providers of commercial health insurance in the Lansing area. Blue Cross-

Michigan had almost a 70 percent market share in Lansing. PHP was its largest competitor with a market share of approximately 20 percent.

The Division's investigation found that the transaction was likely to result in a substantial lessening of competition in the Lansing market for commercial group health insurance and in the market for the purchase of physician services. As suggested by their high shares, Blue Cross-Michigan and PHP were the strongest competitors in the Lansing area and were each other's most significant rivals, creating a likelihood of unilateral price increases in the wake of a merger. Indeed, our investigation found that it was competition between the two companies that had led them to offer lower prices, better service, and more innovative products to employers and their employees, even though Blue Cross-Michigan already enjoyed a substantial market share. The acquisition also would have given Blue Cross-Michigan the ability to control physician reimbursement rates in a manner that could have harmed the quality of health care delivered to consumers.

However, the Division is also sensitive to the capacity of certain mergers or collaborations to improve efficiency both in health care and health insurance markets, and so we have pursued a measured approach. Over the past year, we have closed investigations in the health insurance market after thoroughly analyzing our initial concerns and satisfying ourselves that the transactions under investigation were unlikely to pose a competitive problem. Where the Division has been convinced through direct evidence and economic analysis that a practice or proposed combination is not likely to result in a substantial lessening of competition, we have not challenged it.

The Division is committed to vigorously, but responsibly, scrutinizing mergers in the health care industry that appear to present a competitive concern. If we determine that our initial concerns were well founded, we will not hesitate to block the merger or to require the settlement concessions necessary to protect consumers. On the other hand, if we do not find that the merger may substantially lessen competition, we will promptly close the investigation and allow the parties to try to show, through the competitive process, that better business methods can deliver more efficient medical care and medical insurance to American consumers.

This kind of measured scrutiny is not limited to the health insurance industry. Anticompetitive conduct and the exercise of market power by health care providers also can harm consumers and violate the antitrust laws. Accordingly, while many hospital mergers and acquisitions do not present competitive concerns, the Division, along with the Federal Trade Commission, does investigate hospital mergers and will act to prevent those mergers that are likely to reduce competition. In that effort, we use the same analytical framework that we use for other mergers. Similarly, in recent years, there has been a trend towards consolidation of specialists either through the merger of practice groups or through acquisitions by hospitals. Again, while many of these transactions do not raise competitive concerns, the Division carefully reviews them to determine whether they are likely to harm consumers through higher prices or lower levels of service.

Industry Analysis

As our recent health care investigations strongly suggest, it is essential that we continue to refine and expand our understanding of market forces, structures, and dynamics in the health care industry. Of course, that imperative is not unique to health care: we seek to achieve sophisticated, industry specific, and up-to-date expertise in every line of business with which we routinely interact. Yet because the relative challenges for new entrants are such an important part of the competitive analysis in health insurance matters, the Antitrust Division recently undertook a review to gather further expert experience and insight about the significance and nature of entry and expansion in that industry.

We looked to sources both inside the Division, which has extensive experience conducting health insurance investigations, and outside of it. In particular, we reviewed a substantial number of Division cases and investigations in the health insurance industry since 1996, closely scrutinizing those matters where de novo entry or expansion was relevant to our analysis. We also interviewed a number of insurance brokers, economists, and state officials with expertise in this area. Finally, we asked health plans themselves about the barriers they face in entering new markets or expanding within existing ones, all in an effort to better inform our approach to the industry and to particular enforcement matters.

As a result of this review, it is apparent that strong barriers to entry and expansion exist in health insurance markets. This is particularly significant in light of the enactment of the Affordable Care Act. As I noted earlier, one of the major goals of health care

reform is to provide individuals and small businesses with more affordable health insurance options through competition in new state-based health insurance marketplaces called Exchanges. As Chairman Conyers noted, Exchanges must be able to "harness the power of competitive market incentives as fully as possible." Statement of Representative John Conyers, Jr.,156 Cong. Rec. E455-56 (2010). It is therefore imperative that the Division prevent mergers or acquisitions that will create or increase the size of dominant health insurance plans.

Thus, there are some important takeaways. First, the Justice Department will carefully review mergers in the health insurance industry and will continue to challenge those mergers that are likely to substantially lessen competition. The rarity of successful entry of new choices makes it even more important to preserve the choices already available. Second, entry defenses in the health insurance industry generally will be viewed with skepticism. Third, you should expect the Justice Department to carefully scrutinize and continue to challenge exclusionary practices by dominant firms—whether for-profit or non-profit—that substantially increase the cost of entry or expansion. The Division is working closely with state attorneys general, in particular, to determine whether there are most-favored-nations clauses, exclusive contracts, or similar arrangements between insurers and significant providers that reduce the ability or incentive of providers to negotiate discounts with aggressive insurance entrants. Attention to these three takeaways is the cornerstone of appropriate antitrust enforcement in this important sector of our economy.

Competition Advocacy

It is important to keep in mind that successful antitrust enforcement also includes effective competition advocacy. For example, in 2008, the Division filed an important set of comments involving the Michigan state legislature's consideration of a certificate of need (or CON) requirement as a precondition to opening a new facility. (These comments are available at *www.justice.gov/atr/public/comments/234407.pdf*.) The comments focused on a proposed CON standard for Proton Beam Therapy Services, an important treatment for cancerous tumors. As the Division's letter made clear, the CON standards "[had] the potential to delay or exclude a competing and perhaps superior technology from entering the marketplace" without yielding any real offsetting advantages because the market itself could determine the "need" for the facility. Opposing enactment of this legislation was particularly important because, as our letter noted, the state action doctrine often protects such programs from antitrust enforcement. Consequently, competition advocacy was likely the only avenue for promoting and protecting competition in this context. The Division is also prepared to work with its sister agencies in the federal government to identify opportunities for those agencies to advance competition policy goals in the health care sector and will engage with those agencies as the Affordable Care Act is implemented.

Our business review program provides another avenue for effective competition advocacy in the health care industry. For example, on April 26, 2010, the Division issued a business review indicating that we would not challenge a proposal to establish an information exchange program providing data on the relative costs and resource

efficiencies of more than 300 hospitals in California. A coalition of three group purchasers of health care services, serving more than seven million people, proposed to collect, analyze, and distribute aggregated comparative data on the level of reimbursement received, and the resources used, by California hospitals in providing inpatient and outpatient services. In response to the coalition's business review request, we stated that the proposed exchange could potentially reduce health care costs by improving competition among hundreds of hospitals in California and facilitating more informed purchasing decisions by group purchasers of health care services. We noted that the program was likely to provide greater information and increased transparency about the relative costs and utilization rates of hospitals in California to payers and employers. It was also unlikely to produce anticompetitive information-sharing effects because the program would disclose only aggregate data and would involve only data that was at least ten months old.

Conclusion

I hope I have made clear that the Justice Department believes that antitrust enforcement and competition advocacy have—and will continue to have—an essential role to play in health care. If health care reform is to harness the power of competitive markets to produce more efficient systems and higher quality health care delivery, then we must be up to the challenge of ensuring that our health care markets are, in fact, as competitive as possible—protected from undue concentration or anticompetitive conduct with vigorous but responsible enforcement and effective competition advocacy. In this

dynamic environment, a successful effort will require more than "business as usual." It will require that we provide clear and accessible guidance to health care consumers, providers, and payers so that there is the predictability needed for health care reform to succeed. I think you will find the Department of Justice generally, and the Antitrust Division specifically, up to the task of ensuring that reform is achieved, competition is maintained, and consumers are benefited.

Mr. Chairman, this concludes my prepared statement. I would be happy to address any questions that you or the other members of the Subcommittee may have.

Mr. JOHNSON. We will now begin questioning, and I will start with the first round.

What a dominant health insurance company in a market has the clout to make a take-it-or-leave-it offer of below-cost reimbursement rates, what is a sole practitioner or a small physician group

supposed to do? And this is a question first to Mr. Feinstein and next to Ms. Pozen.

Mr. FEINSTEIN. Well, I will, of course, defer to Ms. Pozen on the premise regarding market power on the insurer side.

With respect to what physicians can do, there is no question that it is difficult for a solo practitioner physician to resist that situation alone. I don't think there is any dispute about that. And if they choose to collaborate in order to address that, there are ways that they can do that fully consistent with the antitrust laws. And we have laid out in great detail over the years ways that they can do that.

Mr. JOHNSON. Would you share with us some of those methods?

Mr. FEINSTEIN. Well, for example, going back to the guidelines that were issued in 1996, there have been—there is a fairly extensive description in general terms of methods of financial integration, of methods of clinical integration, both of which have been elaborated upon subsequently in advisory opinions. There are also opportunities for physicians to form entirely merged groups, which has happened in many segments of the country where individual physicians have formed unified practice groups. All of that is genuinely welcomed under the antitrust laws and certainly doesn't pose condition concerns. What does pose concerns——

Mr. JOHNSON. If I might interrupt, how do those measures apply to a physician's ability to contest a reimbursement rate imposed by a dominant health insurance company in that market?

Mr. FEINSTEIN. Well, if it could be demonstrated that the rate that was being imposed by the insurance company was in some sense below cost, if it was going to have the effect, and it could be demonstrated that it was going to have the effect, of reducing the supply of physician services in a properly defined market, that may well be actionable under the antitrust laws against the insurance company.

Mr. JOHNSON. That would require basically a private lawsuit; would it not?

Mr. FEINSTEIN. It could be a private lawsuit, or it could take the form of enforcement by the Department of Justice or by a State attorney general. Historically the FTC has deferred to the Antitrust Division with respect to enforcement actions involving the insurance industry.

Mr. JOHNSON. Can you cite to us any case where that has occurred?

Mr. FEINSTEIN. Where what has occurred?

Mr. JOHNSON. A small physician group or solo practitioner who is told that you will be reimbursed at this rate, and that rate is not profitable, it is below cost, and there has been a complaint to DOJ or FTC, and action has been taken to address the issue.

Mr. FEINSTEIN. I would have to defer to Ms. Pozen about the extent to which that issue has arisen in the form of complaints.

Mr. JOHNSON. Do you know of any?

Mr. FEINSTEIN. On those specific facts I think those allegations have been raised from time to time, and I suspect that they have been the subject of investigation from time to time. I am not aware of a case on those particular facts.

Mr. JOHNSON. Okay. Well, let us hear from Ms. Pozen.

Ms. POZEN. Sure. Thank you, Mr. Chairman.

It is exactly the issue that we came upon when we were looking at the Michigan Blue Cross Blue Shield acquisition of PHP in Lansing. Not only did we have a concern about the commercial group insurance markets because that merger would have resulted in a 90 percent market share, by our estimation, but we were also concerned about, as you put it, the purchase of physician services there. We thought that kind of dominance could affect the physicians and the kinds of rates that they could negotiate. So that was precisely the issue in that case, sir.

Mr. JOHNSON. Is that the first time that any action has been taken with respect to a reimbursement schedule that was published and imposed upon a solo or physician group?

Ms. POZEN. That potential harm, again, in the context of an acquisition, was looked at previously, and again, an acquisition of health insurance companies. When Aetna was acquiring Prudential, that was part of the allegations in that complaint, which ended in a consent agreement, and I believe in other mergers.

Again, just as Mr. Feinstein pointed to, the reason that we find this issue and have concerns and try to resolve those concerns, just as we did in the Michigan Blue Cross Blue Shield acquisition, is because we don't want to create dominant health insurance who can then affect physician services.

Mr. JOHNSON. Thank you. My time has expired. I will now yield to the Ranking Member.

Mr. COBLE. Thank you, Mr. Chairman.

Good to have you both with us this morning.

Mr. Feinstein, some physicians complain that the process for obtaining business review letters for cost-sharing arrangements is too costly and burdensome to be practicable for most physician groups. Do you have any practical suggestions as to how physicians could obtain a more prompt guidance from the FTC?

Mr. FEINSTEIN. Yes, I do. Thank you, Mr. Coble.

First of all, I think that there is a substantial amount of guidance in the form of letters that have already been issued and in the form of informal advice through speeches, through inquiries that are made to our healthcare shop. At the conference that was held last October, which was focused to some degree on accountable care organizations, what I alluded to in my opening statement, a number of the representatives of physician groups indicated their belief that the guidance that is out there right now is well understood. And I believe that there are many, many groups of physicians who are able to rely on that guidance and go forward without being challenged, but also without seeking a formal advisory opinion or business review. In some instances, they elect to do that. When they do, we have the obligation to make sure we understand the facts carefully and issue a reasoned letter.

But I believe it is frequently the case that organizations are relying on the guidance that is out there in going forward without seeking formal advisory opinions. And I base that in part on my own experience in private practice.

Mr. COBLE. Thank you, sir.

Mr. Feinstein, does the FTC plan to revise its 1996 healthcare guidelines?

Mr. FEINSTEIN. Do we have plans to revise them; is that the question? At the moment we do not have plans to revise them beyond the extent to which they have already, in my judgment, been enhanced through the letters that have been issued over the years and the speeches that have been given, et cetera. We obviously are open to revising them as that is deemed to be appropriate, but when they were written, they were written rather broadly, and there is a substantial body of advice that has been issued over the last 14 years which I think takes the form, in effect, of updating the guidelines.

Mr. COBLE. I thank you.

Ms. Pozen, let me put a three-part question to you, if I may. How many antitrust actions has DOJ brought against physicians in the last 10 years; how many actions against hospitals; and how many actions against health insurers in that same timeframe?

Ms. POZEN. I don't know that I can give you precise numbers, but I can provide your staff those figures if you would like them. The Antitrust Division looks at all aspects of the healthcare industry. Since I have been at the Division, we have brought one case involving physicians and two cases involving health insurance companies. We have reviewed many and have many ongoing investigations.

Mr. COBLE. If you can give us the detailed numbers, I would appreciate that.

One more question, if I may, Mr. Chairman.

We have heard complaints from physicians that the messenger model is cumbersome and outdated. If you would, Ms. Pozen, define the messenger models. And can you give us an example of how a lawful messenger model would work, and what benefits would a helpful messenger model bring to physicians who use it?

Ms. POZEN. Sure. I think, as Mr. Feinstein pointed out, there are a number of ways that physicians can collaborate and work together jointly. One of those ways is through the messenger model, as you pointed out. The idea is that physicians, like any other entities, are otherwise competitors. And so one concern is that when physicians join together in ways that abut and run afoul of the antitrust laws, it can be considered price fixing.

The messenger model is one way to avoid such allegations and not run afoul of the antitrust laws. The idea is using sometimes a third party or another means whereby you can negotiate with the insurance companies, but make sure that there isn't price fixing among the physicians. So that is the messenger model, and that is how it can operate.

Mr. COBLE. Thank you, Ms. Pozen.

Thank you both.

Thank you, Mr. Chairman. I yield back.

Mr. JOHNSON. Thank you, Mr. Coble.

Next, we will have questions from Mr. Conyers.

Mr. CONYERS. Thank you.

Nobody has talked about the concentration of the health insurance markets. Would you say something about that?

Ms. POZEN. The question is to me, sir? I hope I was addressing such issues, sir, by ensuring that we vigorously enforce the antitrust laws, that we prevent further undue concentration in——

Mr. CONYERS. That doesn't say anything about a concentration. It tells me how good you think you work over at DOJ. Let us talk about the concentration.

Ms. POZEN. Okay. Well, I think in our Michigan Blue Cross Blue Shield MFN case, there we did find undue concentration, and we found that there were contracting methods and techniques that Blue Cross Blue Shield of Michigan was using.

Mr. CONYERS. Besides that case.

Ms. POZEN. Well, as I made clear, and I think as we made clear when we announced that case, that if we find health insurance companies with dominance use

anticompetitive methods, anticompetitive contracting methods, that we will stop them, and we will prosecute. And we will try to prevent further concentration through our merger enforcement.

Mr. CONYERS. Well, what about is there concentration?

Ms. POZEN. We have found that there is concentration.

Mr. CONYERS. How much concentration?

Ms. POZEN. Well, in the particular enforcement actions that I mentioned, we found that the——

Mr. CONYERS. Well, that is three.

Ms. POZEN. There are a variety of studies out in the public documenting concentration in the health insurance area.

Mr. CONYERS. What if you came across a statement that said there have been over 400 healthcare mergers in the last 10 years? Would you accept that as correct?

Ms. POZEN. I would trust you, sir.

Mr. CONYERS. Well, what about you, though? I don't work over there with you every day. Matter of fact, this is the first time we have ever met. Have you ever heard of that statement before?

Ms. POZEN. Yes, sir, I have.

Mr. CONYERS. Well, then, why haven't you told the Committee when I have asked you about four times about the nature of the concentration of healthcare insurers in the market, and you named three cases?

Ms. POZEN. Well, since I have been at the Antitrust Division, those have been three significant cases that we have brought in that area in the time that we have been there. The other acquisitions that go on, some of them can raise serious competitive issues, and some of them do not. And some of them provide for efficiencies, and some do not. We will take each case as it comes and evaluate it on its facts, and we will vigorously enforce the antitrust laws.

Mr. CONYERS. But you look into the past, don't you? I am not holding you responsible for the past history. You have been in this job a year. Do you believe that there have been over 400 healthcare mergers in the last 10 years? You don't know for sure?

Ms. POZEN. I would take that as a fact. I don't know the precise number, no, sir.

Mr. CONYERS. Well, would you examine that for me?

Ms. POZEN. Yes, sir.

Mr. CONYERS. And we are going to be writing—there will be communication after the hearing—about whether or not there have been that many mergers. Does that seem like a large amount to you, if it is accurate?

Ms. POZEN. I wouldn't be able to comment on that.

Mr. CONYERS. You are not sure. But you are going to find out for the Committee?

Ms. POZEN. Yes, sir.

Mr. CONYERS. Okay. Now I will go on to the next sentence. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated, and the number of insurers have fallen by just under 20 percent since 2000. Have you ever heard that statement before?

Ms. POZEN. Yes, I have, sir.

Mr. CONYERS. Do you believe it?

Ms. POZEN. I don't doubt its veracity in the context in which you are raising it, sir.

Mr. CONYERS. Well, now wait a minute. Do you believe it or not?

Ms. POZEN. I don't have the statistics.

Mr. CONYERS. You don't know.

Ms. POZEN. Exactly.

Mr. CONYERS. You will have to study this.

Ms. POZEN. Yes, sir.

Mr. CONYERS. And you will include that in our communications.

Ms. POZEN. Absolutely.

Mr. CONYERS. All right. Do you know that the President of the United States has said that he would step up and reinvigorate antitrust enforcement in the area of healthcare?

Ms. POZEN. Yes, sir.

Mr. CONYERS. You heard that?

Ms. POZEN. Yes, sir.

Mr. CONYERS. You know that.

Ms. POZEN. Yes, sir.

Mr. CONYERS. And you are doing that.

Ms. POZEN. Yes, sir.

Mr. CONYERS. Because you have cited me three cases repeatedly this morning.

Ms. POZEN. Yes, sir.

Mr. CONYERS. Do you know how many other cases that could be prosecuted?

Ms. POZEN. I don't have those figures. I can tell you the cases that come to us, or that we look for, or that we find, and that we vigorously prosecute those who violate the antitrust laws.

Mr. CONYERS. Well, if you believe that there have been 400 healthcare mergers in 10 years, and you know that the President wants to step up antitrust enforcement, it seems like some of those might be subject to review. I mean, what I sense is that you are really on the case from this point forward, but you sort of act, Ms. Pozen, as if there is no history of antitrust law in healthcare, that this is a new subject. And you keep citing me three lousy cases as a proof that you are on the job, and you brag about the Department of Justice's effectiveness in this area.

Now, what about the mergers—well, let me just close. My time has expired. Do you know that there is a concentration of merger activity in our economy that has been going on for at least a dozen years or more?

Ms. POZEN. I do, sir, and I have only been at the Antitrust Division for a short time in the Obama administration, and as I said, we are vigorously enforcing the antitrust laws. We are mindful of

the past, the present, and the future, and doing what we can to ensure that either dominant firms don't abuse that dominance or that further dominance doesn't occur.

Mr. CONYERS. Well, just allow me just this one question. Thank you very much for this. But if you are vigorously enforcing antitrust laws, and you know that we are in the wave of an—that mergers are going on, and have been, at an unprecedented pace, how can you prosecute if you are not reviewing the past cases?

Ms. POZEN. In terms of the cases that we have looked at in the mergers that come forward, we are carefully analyzing them. We are looking at the facts and applying the law. Not every merger is anticompetitive. I will assure you of that. But I will assure you that those that are anticompetitive, we will prosecute.

Mr. CONYERS. All right. I thank you very much.

I will have to send you, Mr. Feinstein, the questions that we would have engaged in.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you, Mr. Chairman.

Next, Mr. Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman. Thank you for holding this hearing, and I want to thank both of our witnesses for being here today.

Mr. Feinstein, I want to follow up on the questions of the Ranking Member Mr. Coble, who asked about some of the concerns that doctors have about obtaining business review letters for cost-sharing arrangements. How long does it normally take the FTC to produce a business review letter?

Mr. FEINSTEIN. It really depends entirely on the scope of the request. We react to specific requests.

I want to emphasize, by the way, before I address formal letters, there is a lot of informal guidance that goes on where folks call up our staff and get informal guidance. It may not take the form of writing, but they can take some comfort from that.

Mr. GOODLATTE. If they are going to make a major business decision about whether they can proceed with an arrangement, they probably want something more formal.

Mr. FEINSTEIN. Yes. And when that happens, they have an obligation to describe pretty completely the facts surrounding their proposal, and we have an obligation to make sure we understand those facts. It is an iterative process. Often they come to us with a proposal. We may have questions about how it is going to be implemented.

Mr. GOODLATTE. Is there an average amount of time?

Mr. FEINSTEIN. If there is an average amount of time, I haven't calculated it.

Mr. GOODLATTE. Could you calculate it and provide it to the Committee?

Mr. FEINSTEIN. We can certainly do that, yes.

Mr. GOODLATTE. This is pretty important because if you are making a decision that potentially is going to affect your ability to continue your business, redesign your business, expand your business, and you need to have guidance about whether or not you can do it, you want to proceed quickly. When you go in the private sector to get advice from attorneys, and accountants, and consultants and

so on about the decisions you make, you get pretty prompt replies. And it is important that the government understand that and the importance of giving prompt replies as well. So if you could provide that information to the Committee, I would appreciate it.

Mr. FEINSTEIN. I certainly share that goal of giving prompt replies.

Mr. GOODLATTE. Thank you.

Does the FTC have a role in examining mergers among health insurers?

Mr. FEINSTEIN. No. Historically we have deferred to the Department of Justice. I think largely that is because years ago most of the insurers, particularly the Blue Cross and Blue Shield organizations, were set up as nonprofits originally. Some of them have converted to for-profit status. But because, as you probably are aware, there are some limitations on our jurisdiction with respect to the activity of nonprofit entities, over the years a tradition unfolded whereby the Justice Department took the lead on health insurance mergers. And there have occasionally been matters that the FTC has looked at in the last 15 or 20 years, but it has been quite rare, and none that I can think of in the last decade or more.

Mr. GOODLATTE. Are there any statutory impediments to bringing actions by the FTC with regard to health insurance mergers?

Mr. FEINSTEIN. Other than the one I alluded to, no. We enforce section 7 of the Clayton Act. That can be applied to health insurance mergers. There is, of course, the

McCarran-Ferguson exemption for the business of insurance, but I think it is pretty widely recognized that that does not shield health insurance mergers from antitrust scrutiny by either agency.

Mr. GOODLATTE. Does the FTC plan to revise its 1996 healthcare guidelines?

Mr. FEINSTEIN. As I said, we don't have current plans to revise them. I am not saying that it won't happen, I'm just saying we don't have a current plan to do that. The principal reason for that is that we believe that it is, in effect, a living document with the updating taking the form of the advisory opinions that have been issued over the last 14 years. That is not to say that there may not be an occasion to do it.

And I would also note that we are, as both, I think, Ms. Pozen and I addressed—we are, of course, looking at the question of providing guidance with respect to accountable care organizations in real time. That is something that the agencies are working together on right now. And I think it is reasonable to assume that to some degree that guidance will be relevant to clinical integration otherwise, although there are some distinctions that will have to be kept in mind.

Mr. GOODLATTE. Let me interrupt you and ask one more question here. With regard to the new healthcare bill, what are some the antitrust safe harbors that the FTC might be considering with respect to the formation of the accountable care organizations that have been created by that legislation?

Mr. FEINSTEIN. Well, that is very much a work in progress. I think just as there are safe harbors that are in the current guidelines relating to market share, for example, and certain types of conduct, those are the types of issues that we and the Justice De-

partment are considering. It would be premature for me to make a definitive statement about what form that will take, because it is literally something that we are discussing between the two agencies and with CMS on a weekly basis.

Mr. GOODLATTE. Under the law, when can accountable care organizations come into being? Is there a timetable for that?

Mr. FEINSTEIN. My understanding—and I will defer to Ms. Pozen if she has a clearer understanding—my understanding is that CMS intends to issue regulations early next year.

Is that correct?

Mr. GOODLATTE. Could they be formed right now if the regulations existed?

Mr. FEINSTEIN. I assume that the answer to that question is yes.

Mr. GOODLATTE. I know there are various phase-ins of various aspects of the bill. Your understanding is they could occur right now. So, again, the sooner you have information available, the sooner these organizations might be formed.

Mr. FEINSTEIN. Well, I think there is an expectation that some of the antitrust issues and the way they will be analyzed will be reflected in the regulations to be issued as well an additional statement to be made by the antitrust enforcement agencies.

Mr. GOODLATTE. Ms. Pozen, do you want to add anything to that?

Ms. POZEN. As I indicated in my statement, we are committed to providing guidance and providing expedited review of ACOs. We have a business review process that today if an ACO is forming, they can come in and seek our guidance on an informal or formal basis.

I hope that answers your question.

Mr. GOODLATTE. Are there regulations that DOJ is going to issue at some point that would give guidance as to whether or not it is desirable to form one of these in terms of what kind of safe harbors, antitrust safe harbors, might be available?

Ms. POZEN. Well, the ACOs that are being formed to take Medicare and Medicaid funding are subject to CMS regulations, as Mr. Feinstein indicated. That is an ongoing process and an ongoing discussion that we have with CMS and the FTC regarding how to provide antitrust guidance in that context so that, just as you said, ACOs have guidance going forward in order to receive those funds through CMS. So that is an ongoing process now, but, as I said, in the interim we have a business review process. If ACOs need advice, we are happy to give it to them.

Mr. GOODLATTE. Thank you.

Thank you, Mr. Chairman.

Mr. JOHNSON. Next we will hear from Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. I want to thank the witnesses for their testimony. The first question is—if you will just answer yes or no, it makes it a lot easier—do we have a competitive health insurance industry in the United States today? Mr. Feinstein. Just yes or no. And remember, I know these are your personal opinions and not the Department or Commission.

Mr. FEINSTEIN. Well, it is hard for me to answer that yes or no because my agency doesn't focus on that issue to the extent that the Department of Justice does. I think it really varies, candidly, market by market. There are some markets that are more competi-

tive than others, I would say. I don't know that I would be comfortable answering the question on a national basis.

Ms. POZEN. I would echo Mr. Feinstein's answer. I know there are some areas where there is vigorous competition and there are some areas where I presume there isn't. And if those areas are subject to a merger where there will be, you know, more concentration created as a result of the merger or a dominant firm is using that market power in an illegal way, we will prosecute.

Mr. GONZALEZ. I am not sure—the answer for all of us has to be no. And that is the reality and that is where we find ourselves. And I am not sure that any of us had anything to do with the direction things took and where we find ourselves today. But it is a precautionary tale maybe going forward. And the reason I say that is, what I am looking at, insurance market concentration ranked as of 2007. So this is old information. I only suggest it has probably gotten worse. But if we go State by State, combined market share percentage of the top two insurers in every State in this Nation, and I don't get to—at 48 percent, where basically two insurers comprise 48 percent, some may say, Wow, that may be acceptable. I am not sure that is really acceptable. But that is like number 40 in the ranking. Everyone else has anywhere from 53 to 98 percent of the market share by two insurers.

Now how can anyone in good faith today not answer my question as "no"? I mean, maybe it is just out of necessity and that is the way things grew and that is what you are going to have. And we have to abandon the goal of competition in order to achieve competition. That is the whole thing about—remember with TARP, we had to abandon free market principles in order to save the free market. Well, maybe we do that all the time, Mr. Chairman. I am not sure.

So let's talk about doctors quickly. Doctors are at a tremendous disadvantage. My own observation is that they are just not as organized as the insurance industry or as the hospitals. They are rather busy practicing medicine. That occupies all of their time. I also believe that, you know, they are not as unified because of the specialties today. But nevertheless we are asking them to do something to make health care reform a reality. So I am just going to ask you—and I know I am going to revisit some of this. But if I was a physician and I am looking to be part of these ACOs and I don't want to expose myself out there and I don't have all of the lawyers and the big firms, lobbyists, advocates, and so on that are the organizations but I want to be part of the answer in this solution, what assurances can you give these doctors that they are not going to run afoul?

So you are telling me that there is coordination among the FTC, the Department of Justice, and the Inspector General over at HHS. That is correct, isn't it? Y'all are coordinating your efforts. So you are going to provide guidelines. And I strongly suggest that guidelines can't be given in some speech or some conference or some convention. That just doesn't work in the real world. They have to be black letter. They have got to be able to see it. Because my fear is, you have a lot of discretion and wiggle room to pass judgment on these things after the fact.

To what extent do you provide beyond guidance but something more in the manner of preclearance? So I am not familiar how you do this or how the HHS and the Inspector General does it. But if I am a doctor or a group of doctors and I am trying to do this, what assurance can you give me that it is a safe thing to do and that I am not going to be penalized down the road?

Mr. Feinstein.

Mr. FEINSTEIN. I think there are—and I think you are going to see this as a result of the ongoing ACO effort that is underway. I certainly think there is certainly a recognition in the enforcement agencies that this is a circumstance where safe harbors with a clear expression of the boundaries of the safe harbors is appropriate, and also a clear expression that circumstances that are outside the precise boundaries of the safe harbor aren't necessarily going to violate the law. From the standpoint of an individual physician, something that I think is important to remember is that, you know, if what they are hoping to accomplish is something that is likely to lead to more efficient delivery of care and higher quality, something that is going to serve the interests of consumers, we are not going to get in their way. We want that to happen. Where we step in are the circumstances where there is nothing going on other than increased prices. I am happy to report that in the last—you know, in recent years, we haven't seen as much of that. We haven't brought as many of the cases. Our resources overall in the health care sector are not disproportionately directed at the physician segment of the market. We spend a great deal more of our time these days on the pharmaceutical sector and on hospitals. But that doesn't mean that there aren't areas where, just as there may be markets where health insurers have market power, there may also be specific markets where hospitals have market power or where you know there are must-have groups of physicians. That is different of course from the individual physician. But I would go back to four sort of first principles. If the goal is to do something that is going to improve care and ideally even lower costs, we are not going to—we are going to bless that as quickly as we can.

Mr. GONZALEZ. Ms. Pozen.

Ms. POZEN. As I said, we are committed to guidance. We are working with CMS, HHS, and the Federal Trade Commission on what that guidance will precisely be to address the issues that you have pointed out. We want these organizations to go forward, to feel comfortable integrating, to feel comfortable innovating and not stand in the way and not inhibit that. It is an iterative process at this point, as CMS develops its regulations, but we do want there to be guidance, potentially safe harbors, and an expedited review as part of that.

Mr. GONZALEZ. Thank you very much. Thank you, Mr. Chairman, for your indulgence.

Mr. JOHNSON. Thank you, sir. And with another question, I will recognize Chairman Conyers.

Mr. CONYERS. Just a closing question. Had either of you heard about the concentration of health insurers in this country by State that Judge Gonzalez referred to when he was talking with you?

Ms. POZEN. Yes.

Mr. CONYERS. You had heard about that?

Ms. POZEN. Yes. And it is one of the reasons, as I mentioned in my statement, we wanted to figure out how that happened. Just getting to exactly your question. How could that happen? And what we found was, when we focused on entry and we found that there are barriers, as I indicated in my statement, there are barriers to new entry. New insurers can't come in and take on some of these dominant players. So that learning that we did right off the bat when we got into office is infusing all of our thoughts and all of our investigations on this issue.

Mr. CONYERS. So why couldn't you answer "no" to his question? Come on. You can tell us. What is the real reason?

Ms. POZEN. Well, I think that when you look at health insurance markets, you can look at them on a statewide basis, you can look at them on an MSA basis, and on a local basis.

Mr. CONYERS. But you end up with the same answer every time. They are all concentrated.

Ms. POZEN. And we are——

Mr. CONYERS. Aren't they, Ms. Pozen? Now, look, this is your job.

Ms. POZEN. I know, and we are trying to figure out why, I can assure you of that. And we are trying to do what we can not to allow more of it, and we are trying to assure that those insurers that are dominant aren't using that dominance in an anti-competitive way.

Mr. CONYERS. But why didn't you answer "no"?

Ms. POZEN. Why didn't I answer "no" to the question of whether or not——

Mr. CONYERS. You know what the question was.

Ms. POZEN. Yeah. Because I hate to say it. We are lawyers, and we always want to say it depends. I don't mean to be flip, sir. I really am not. I do understand the gravity of the issue and respect the——

Mr. CONYERS. Mr. Feinstein, why couldn't you answer "no" to his question?

Mr. FEINSTEIN. Let me be clear about my personal view on this.

Mr. CONYERS. That is what I want.

Mr. FEINSTEIN. I accept the proposition that there are some markets——

Mr. CONYERS. Do you know of any market not concentrated in health insurance?

Mr. FEINSTEIN. The level of concentration varies from market to market.

Mr. CONYERS. Do you know of any market? Just answer the question.

Mr. FEINSTEIN. Do I know of any market that is not concentrated? With all due respect, it depends on what you mean by concentrated. There are certainly markets that have high concentration——

Mr. CONYERS. Oh, I see. I get it. I get it. I get it.

Mr. FEINSTEIN. But there is variation. The question was nationally.

Mr. CONYERS. Let me just close with this. Do you know how many people in America do not have insurance? You nod your head. What is the answer?

Ms. POZEN. Millions do not have insurance.

Mr. CONYERS. Millions? How many millions?

Ms. POZEN. I don't have the exact figure.

Mr. CONYERS. What about you, Mr. Feinstein?

Mr. FEINSTEIN. I don't know a precise number. I will just say too many.

Mr. CONYERS. Okay. Thank you, Mr. Chairman.

Mr. JOHNSON. Well, it is true it is about 40 million, isn't it?

Mr. CONYERS. 50 million.

Mr. JOHNSON. 50 million? 50 million people.

I would like to thank the FTC and DOJ for appearing before our Subcommittee today. You are excused. Thank you very much.

Mr. FEINSTEIN. Thank you, Mr. Chairman.

Mr. JOHNSON. And I will invite the second panel to take its place.

Ladies and gentlemen on our second panel, we have Melinda Hatton, Senior Vice President and General Counsel to the American Hospital Association. Welcome, Ms. Hatton.

Next witness is Arthur Lerner, a partner at the law firm of Crowell & Moring LLP, on behalf of America's Health Insurance Plans. Welcome, Mr. Lerner.

Next to Mr. Lerner is Dr. Peter Mandell on behalf of the American Association of Orthopaedic Surgeons. Welcome back, sir.

Our next witness is Dr. Michael Connair on behalf of the American Federation of State, County, and Municipal Employees. Welcome, sir.

Dr. CONNAIR. Thank you.

Mr. JOHNSON. And finally we have David Balto, Senior Fellow with the Center for American Progress. Welcome back, Mr. Balto.

Mr. BALTO. Thank you very much.

Mr. JOHNSON. Ms. Hatton, please proceed with your testimony.

TESTIMONY OF MELINDA HATTON, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION

Ms. HATTON. Thank you, Mr. Chairman. I am Melinda Hatton, General Counsel and Senior Vice President for the American Hospital Association. On behalf of our more than 5,000 member hospitals, health systems, and other health care organizations and the nearly 200,000 employed physicians, the AHA thanks you very much for the opportunity to discuss the impact of the antitrust laws on our Nation's hospitals and our hospitals' efforts to improve quality and efficiency.

Our antitrust concerns are twofold. First, we support timely, user-friendly guidance from the antitrust agencies on how the laws will be applied to clinical integration efforts among health care providers. Second, we urge the Department of Justice to be increasingly vigilant about anti-competitive behavior on the part of health insurers and we commend the Department for its recent stepped-up enforcement.

Our health care delivery system is fragmented. A typical Medicare patient sees two primary care physicians and five specialists, working in four different practice settings in a single year. The numbers escalate greatly for those with chronic conditions. Most health care providers work alone in small groups or in specialty practices. Most physicians still don't work for hospitals. Care is provided in multiple locations, from free-standing ambulatory clin-

ics to post-acute settings to patients' homes. Some of these settings may be affiliated with a hospital while many are not. It is an insufficient system that is hard for any patient, particularly a sick patient, to navigate. Lack of coordination also makes it more likely that tests will be duplicated and adverse drug interactions will not be caught in time.

We know the patients get real benefits when caregivers work together to provide more coordinated, more efficient, higher quality care. The AHA has, since 2004, been seriously engaged in efforts to advance clinical integration among health care providers by, among other efforts, tackling legal and regulatory barriers. At its heart, clinical integration is really teamwork—hospitals, doctors, nurses, and other caregivers working together to make sure our patients get the right care at the right time in the right setting. To do so effectively, we do need user-friendly guidance from the antitrust agencies on how the laws and policies will be applied to clinical integration.

A bipartisan group of lawmakers who sit on the Committees of jurisdiction have agreed that the best solution to tackle these antitrust laws as a barrier to clinical integration is to issue user-friendly, officially backed guidance that clearly explains to caregivers what issues they must resolve in order to embark on a clinical integration program. In three separate letters to the antitrust agencies over 7 months, lawmakers clearly called for such guidance. We continue to urge those agencies to act quickly to provide it.

In addition to guidance, we have urged the Department of Justice's Antitrust Division to be increasingly vigilant about anti-competitive conduct on the part of entrenched health insurers. In May of 2009, when the Administration first came into office, the AHA called upon DOJ to reexamine and bolster enforcement as it applies to health care plans. Hospitals are held accountable for the care they provide to their communities, with quality and patient satisfaction routinely measured and publicly reported on a government Web site. Hospitals also have been subject to intense antitrust scrutiny by the Federal antitrust agencies.

Conversely, insurers have not faced nearly as much public antitrust scrutiny or oversight. Patients receive higher quality, more efficient care when caregivers work together. That is the path we are on and one that holds the greatest promise for fixing a fragmented delivery system. The antitrust laws can make a real contribution if the agencies enforcing them are willing to exercise the same kind of leadership and foresight that led to the issuance of the statements on antitrust enforcement and health care in the early 1990's. User-friendly guidance for clinical integration and more vigilance in the health insurance sector are important steps not just for hospitals but for the future health and vitality of the Nation's health care delivery system.

Mr. Chairman and distinguished Members of the Committee, thank you for the opportunity to discuss these issues with you today. America's hospitals look forward to working with you and all of those who are committed to improving the quality and efficiency of care for patients in every one of your communities. We believe that clinical integration is a proven strategy for achieving these aims and that the efforts of health care providers to improve deliv-

ery should not be impeded by unnecessary barriers, like the antitrust laws.

[The prepared statement of Ms. Hatton follows:]

PREPARED STATEMENT OF MELINDA HATTON

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Testimony
of the
American Hospital Association
before the
Subcommittee on Courts and Competition Policy
of the
Committee on the Judiciary
of the
U.S. House of Representatives

"Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients"

December 1, 2010

Mr. Chairman, I am Melinda Hatton, general counsel and senior vice president of the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 199,000 employed physicians, the AHA thanks you for the opportunity to provide feedback on the impact of the antitrust laws on our nation's hospital, and hospitals' efforts to improve the quality and efficiency of care.

Our concerns about recent trends in antitrust enforcement are twofold: first, we support user-friendly guidance from the antitrust agencies on how antitrust laws and policies will be applied to care coordination, or clinical integration, arrangements among hospitals and other caregivers, and urge those agencies to act quickly to provide such guidance. Second, we urge the Department of Justice's (DOJ) Antitrust Division to be increasingly vigilant about anticompetitive conduct on the part of entrenched health insurers and commend the division for its recent stepped up enforcement.

The current direction of antitrust enforcement needs to coincide with the accelerating pace of change in the nation's health care delivery system. These changes were not created by passage of the *Patient Protection and Affordable Care Act*; rather they were accelerated by it with the promise of support for innovative delivery arrangements such as accountable care organizations (ACOs) and new payment models such as bundled payments, as well as penalties for fragmentation. The success of these delivery system changes depends in no small measure on whether Congress and the Administration are willing to effectively tackle and bring down barriers to needed change, such as those presented by our nation's antitrust laws and policies.

TACKLING THE FRAGMENTATION OF HEALTH CARE DELIVERY

Everyone agrees that the health care system is complex and fragmented and that neither of these attributes contributes positively to patient care. Today, it is clinical integration among caregivers – in its many forms and varieties – that holds the greatest promise of improving the quality and efficiency of our health care delivery system.

At its heart, clinical integration is teamwork: hospitals, physicians, nurses and other caregivers working together to make sure patients get the right care, at the right time, in the right place.

That is different from the way much of health care is delivered today, where providers tend to work separately, in their own "silos" of expertise. Most office-based physicians continue to practice in solo or small groups.[1] Moreover, to the extent that physicians are moving to larger practices, it is generally to form single specialty practices, and not the multi-specialty groups that are best able to support care coordination.[2] A study of Medicare claims from 2000-2002 found that each year the typical Medicare beneficiary saw a median of two primary care physicians and five specialists, collectively working in four different practice settings.[3] Typical patients with multiple chronic conditions saw as many as three primary care physicians and eight specialists in seven different settings. A study by the Robert Wood Johnson Foundation found that for every 100 Medicare patients treated, each primary care physician would typically have to communicate with 99 physicians in 53 practices to coordinate care.[4]

The prevailing model of hospital-physician relationships reflected in the organized medical staff does not assure the optimal level of care coordination between a hospital and independent physicians. In this model, physicians use hospital facilities and rely on hospital staff to provide their services, but the medical staff is not employed by the hospital. As a result, hospitals and physicians have limited tools they can use to positively influence each other's practice patterns to achieve optimal patient outcomes, especially since most forms of economic incentives may run afoul of regulatory barriers such as the Stark, anti-kickback and the Civil Money Penalty laws that apply to Medicare and Medicaid patients.

Care is fragmented because patients receive services in several locations, including freestanding ambulatory sites and post-acute settings or their homes. Some of these settings may be affiliated with a hospital, while others may compete or offer complementary services. This fragmented care can adversely impact quality and efficiency. Without adequate care coordination, patients are more likely to receive duplicative diagnostic testing, have adverse prescription drug

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[1] Hing E., and Burt CW. (2008). Characteristics of Office-based Physicians and Their Medical Practices: United States, 2005–2006. National Center for Health Statistics. Vital Health Statistics, 13(166).
[2] Liebhaber, A., and Grossman, J.M. (2007). Physicians Moving To Mid-sized, Single-Specialty Practices. Center for Studying Health System Change *Tracking Report*, 18:1-5. Accessed at http://www.hschange.org/CONTENT/941/941.pdf.
[3] Pham, H., Schrag, D., et al. (2007). "Care Patterns in Medicare and Their Implications for Pay for Performance." *The New England Journal of Medicine*, 356; 1130-1139.
[4] Robert Wood Johnson Foundation. (2009). *Scope of Care Coordination Daunting for Physicians Treating Medicare Patients*. Accessed at http://rwjf.org.

interactions and have conflicting care plans. These scenarios add to the challenges patients face in navigating the health care delivery system at a time when they are most vulnerable.

In addition, fragmentation also frustrates attempts by hospitals and physicians to improve the quality and efficiency of care. Physicians in small groups are less likely to be able to afford the information technology to implement electronic heath records and similar technologies. They also will have more difficulty in sharing "best practices" and accessing peer data for use as benchmarks.

The AHA began tackling the problem in 2004 by commissioning a Task Force on Delivery System Fragmentation, which concluded:

> Health care is about teamwork and requires the talent and dedication of many – doctors, nurses, technicians and many others. Hospital care is especially dependent on the ability of hospital leaders and physicians to work together to improve the efficiency of patient care and to get patients the right care, at the right time, in the right setting.

Presciently, the Task Force saw that better alignment among providers was the key to improving patient care and enhancing productivity, and that removing impediments to such alignment created by various federal laws and policies was essential. It called upon a variety of federal agencies, including the Federal Trade Commission (FTC) and DOJ to:

> Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements is a significant barrier. Few arrangements can be structured without very significant legal expense.[5]

THE NEED FOR ANTITRUST GUIDANCE TO SUPPORT CLINICAL INTEGRATION

Because of their complexity and potential consequences, the antitrust laws are among the most significant barriers to clinical integration. Moreover, unlike some other barriers, the antitrust laws are always present because they apply whether patients are covered by federal programs, such as Medicare and Medicaid, or through private insurers.

The purpose of the antitrust laws is to protect competition and ensure a level playing field for patients. DOJ's Antitrust Division and the FTC share authority to interpret and apply antitrust laws, and there are serious civil and criminal penalties for violating these laws … even if the violation is unintentional.

[5] AHA Task Force on Delivery System Fragmentation. (2005). *Modernizing Gain Sharing Opportunities*. Accessed at www.aha.org/aha/content/2007/pdf/modernizinggainshare.pdf.

Historically, the antitrust agencies have been skeptical of clinical integration when they involve multiple providers and/or provider organizations because there typically is no conventional shared financial risk. In other words, no "up front" money is at stake; clinical integration seeks to improve care coordination and quality by encouraging caregivers to work together to meet specific practice guidelines and/or quality standards … and rewards them when these goals are achieved. The ability to negotiate together for the payment that will cover the services offered through the clinical integration program is often an essential ingredient in its success, but the agencies have typically frowned upon these activities.

Recently, the antitrust agencies have become more receptive to clinical integration. However, instead of simply issuing guidelines to help caregivers better understand how the laws would be applied, the FTC has issued lengthy and dense staff opinion letters that are expressly limited to the facts contained in the opinion letter and warn that the "*Commission is not bound by the staff opinion and reserves the right to rescind it at a later time.*" The result: caregivers can neither readily understand nor completely rely on those opinion letters, and they remain uncertain about which clinical integration activities will pass muster.

The AHA and a bipartisan group of Senators who sit on the committees of jurisdiction agree that the best solution to tackle antitrust law as a barrier to clinical integration is to issue user-friendly, officially backed guidance that clearly explains to caregivers what issues they must resolve to embark on a clinical integration program without violating antitrust laws. In three separate letters to the antitrust agencies over seven months,[6] lawmakers clearly called for user-friendly antitrust guidance:

> Your agencies could make a significant contribution to [clinical] integration efforts by providing guidance on clinical integration similar to that provided on related topics in the *Statements on Antitrust Enforcement in Health Care*. (Senators Kohl, Leahy, Feinstein, Whitehouse and Specter. November 3, 2009.)
>
> We write to acknowledge and encourage what we hope are renewed efforts by your agencies toward developing and issuing guidance to physicians, hospitals and others in the health care provider community seeking to pursue collaborative care models and different cooperative arrangements to promote high quality, patient-centered care. (Senators Warner, Udall, Bennet, Burris, Kirk, Franken, Udall, Gillibrand and Hagen. December 23, 2009.)
>
> Chief among the challenges to reforming the health care delivery system are federal laws and regulations that discourage collaboration among providers, such as hospitals, doctors, nurses, long-term care providers and others in the health care continuum. Lack of clarity in the antitrust laws and how those laws will be administered by the federal antitrust agencies has contributed to the problem. (Senators Hatch, Cornyn, Roberts, Snowe, Coburn and Graham. June 8, 2010.)

[6] Letters from Senators Kohl, Leahy, Feinstein, Whitehouse and Spector (November 3, 2009); from Senators M. Udall, Warner, Bennet, T. Udall, Burris, Gillibrand, Kirk, Hagan and Franken (December 23, 2009); and from Senators Cornyn, Graham, Coburn, Hatch, Roberts and Snowe (June 8, 2010).

DOJ and FTC have issued user-friendly and officially backed guidance in the past in other areas and, in their 1996 *Statements of Antitrust Enforcement Policy in Health Care*[7], promised to do so again when warranted. Clearly, there is widespread support for them to do so without delay.

THE NEED FOR VIGILANT ANTITRUST ENFORCEMENT FOR HEALTH PLANS

Criticizing the historic lack of a robust and coherent enforcement policy on health insurance plan mergers and anticompetitive conduct in May 2009, the AHA called upon DOJ to re-examine and bolster its enforcement policy as it applies to health plans in *The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform*.[8] Among AHA's requests were that the Antitrust Division:

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

Unlike other sectors of the health care field, such as hospitals and physicians, we pointed out that health plan mergers and other anticompetitive conduct had received comparatively little scrutiny:

> In the past eight years, the Antitrust Division has requested only relatively minor divestitures and other relief in two health plan mergers. In addition, the Antitrust Division has offered no explanation for failing to respond to provider requests for more robust enforcement in the last two major health plan mergers.

While enforcement has been stepped up recently, it is noteworthy that since AHA's May 2009 letter, DOJ has challenged only one health insurance transaction, involving a small provider-owned HMO, while other larger transactions have been cleared.

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[7] Department of Justice and Federal Trade Commission. (1996). *Statements of Antitrust Enforcement Policy in HealthCare*. Accessed at www.ftc.gov/bc/healthcare/industryguide/policy/intro.pdf.

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

Contrasting with that lack of scrutiny was the fact that during the same time period, the FTC launched a major retrospective of the hospital field that was intended to lead to more successful challenges to hospital mergers, apparently in an attempt to overcome losing virtually all of its challenges to those mergers in the federal courts. Following that retrospective, the FTC challenged one long-consummated hospital merger via an internal agency hearing and blocked another outright. The FTC also has aggressively applied antitrust law to arrangements between physicians and between physicians and hospitals, all to "protect" patients from any increase in market power resulting from such arrangements. Where was the comparable focus on health plan mergers and market power?

Today, some would turn the lack of antitrust enforcement against health plans on its head, contending instead that hospitals – the object of so much antitrust scrutiny – have somehow acquired the power to dictate terms to health plans. To examine these claims, the AHA recently commissioned two well-known and respected antitrust economists from Compass Lexecon to evaluate two publications that have been widely cited as support for this mistaken notion: a 2010 *Health Affairs* article about California health care providers[9] and the 2010 report by the Massachusetts Attorney General on health care costs.[10]

In short, the economists from Compass Lexecon concluded, after rigorous analysis, that neither publication contains any credible support for such claims. While the two publications have different but serious flaws, they share one that is particularly glaring: they confuse patient preference for providers with highly differentiated services or specialized service with market power.

> A hospital can become highly desired simply by providing excellent care. Indeed strong consumer preferences for specific hospitals and their services provide an incentive for hospitals to improve services, enhance quality or expand output of services in greater demand, and to expect an appropriate return on the investment required to provide these services.[11]

Hospitals, in particular, are held accountable for the care they provide to their communities; for example, quality and patient satisfaction are routinely measured and publicly reported. Hospitals also have been subject to intense scrutiny by the federal antitrust agencies. Conversely, insurers, which wield enormous – largely unchecked – market power in most markets, have not faced nearly as much public antitrust scrutiny and oversight.

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[9] Berenson, R., Ginsburg, P., and Kemper, N. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform," *Health Affairs*, Vol. 29, No. 4, April 2010.
[10] Office of Attorney General Martha Coakley, "Examination of Health Care Cost Trends and Cost Drivers," March 2010 and Letter to Partners HealthCare, June 2010.
[11] Guerin-Calvert, M., Israilevich, G. (2010). *A Critique of Recent Publications on Provider Market Power*. Compass Lexecon for the American Hospital Association. Accessed at http://www.aha.org/aha/content/2010/pdf/100410-critique-report.pdf.

Most importantly, however, patients get real benefits when caregivers work together to provide more coordinated, more efficient and higher quality care. That is the path we are on and the one that holds the greatest promise for fixing a fragmented delivery system. The antitrust laws can make a real contribution to progress if the agencies enforcing them are willing to exercise the same type of leadership and foresight that led to the issuance of the *Statements on Antitrust Enforcement in Health Care*. User-friendly guidance for clinical integration and more vigilance in the health insurer sector are important steps, not just for hospitals, but for the future health and vitality of the nation's health care delivery system and the patients it serves.

CONCLUSION

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to discuss these issues with you today. America's hospitals look forward to working with you and the Administration to improve the quality and efficiency of care for all patients in every community. It is our belief that clinical integration is one proven strategy for achieving these aims, and that health care providers' efforts to improve care delivery should not be complicated by unnecessary barriers.

Attachment A

Chart of legal barriers to clinical integration and proposed solutions

Law	What Is Prohibited?	The Concern Behind the Law	Unintended Consequences	How to Address?
Antitrust (Sherman Act §1)	Joint negotiations by providers unless ancillary to financial or clinical integration; agreements that give health care provider market power	Providers will enter into agreements that either are nothing more than price-fixing, or which give them market power so they can raise prices above competitive levels	Deters providers from entering into procompetitive, innovative arrangements because they are uncertain about antitrust consequences	Guidance from antitrust enforcers to clarify when arrangements will raise serious issues. DOJ indicated it will begin a review of guidance in Feb. 2010.
Ethics in Patient Referral Act ("Stark Law")	Referrals of Medicare patients by physicians for certain designated health services to entities with which the physician has a financial relationship (ownership or compensation)	Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient's best interest	Arrangements to improve patient care are banned when payments tied to achievements in quality and efficiency vary based on services ordered instead of resting only on hours worked	Congress should remove compensation arrangements from the definition of "financial relationships" subject to the law. They would continue to be regulated by other laws.
Anti-kickback Law	Payments to induce Medicare or Medicaid patient referrals or ordering covered goods or services	Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient's best interest	Creates uncertainty concerning arrangements where physicians are rewarded for treating patients using evidence-based clinical protocols	Congress should create a safe harbor for clinical integration programs
Civil Monetary Penalty	Payments from a hospital that directly or indirectly induce physician to reduce or limit services to Medicare or Medicaid patients	Physicians will have incentive to reduce the provision of necessary medical services	As interpreted by the Office of Inspector General (OIG), the law prohibits any incentive that may result in a reduction in care (including less expensive products)... even if the result is an improvement in the quality of care	The CMP law should be changed to make clear it applies only to the reduction or withholding of medically necessary services
IRS Tax-exempt Laws	Use of charitable assets for the private benefit of any individual or entity	Assets that are intended for the public benefit are used to benefit any private individual (e.g., a physician)	Uncertainty about how IRS will view payments to physicians in a clinical integration program is a significant deterrent to the teamwork needed for clinical integration	IRS should issue guidance providing explicit examples of how it would apply the rules to physician payments in clinical integration programs
State Corporate Practice of Medicine	Employment of physicians by corporations	Physician's professional judgment would be inappropriately constrained by corporate entity	May require cumbersome organizational structures that add unnecessary cost and decrease flexibility to achieve clinical integration	State laws should allow employment in clinical integration programs
State Insurance Regulation	Entities taking on role of insurers without adequate capitalization and regulatory supervision	Ensure adequate capital to meet obligations to insured, including payment to providers, and establish consumer protections	Bundled payment or similar approaches with one payment shared among providers may inappropriately be treated as subject to solvency requirements for insurers	State insurance regulation should clearly distinguish between the risk carried by insurers and the non-insurance risk of a shared or partial risk payment arrangement
Medical Liability	Health care that falls below the standard of care and causes patient harm	Provide compensation to injured patients and deter unsafe practices	Liability concerns result in defensive medicine and can impede adoption of evidence-based clinical protocols	Establish administrative compensation system and protection for physicians and providers following clinical guidelines

The table above comes from the new *AHA TrendWatch* report "Clinical Integration – The Key to Real Reform." For more information on the report, click on the "Research and Trends" section of www.aha.org.

Attachment B

Compendium of AHA Resources on Clinical Integration

Task Force on Delivery System Fragmentation Report, Nov. 2005:
www.aha.org/aha/content/2007/pdf/modernizinggainshare.pdf

Health for Life: Most Efficient, Affordable Care, Dec. 2007:
http://www.aha.org/aha/content/2007/pdf/071204_H4L_Efficient_Affordable.pdf

Ideas for Change: Beginning the Discussion, Mar. 2008:
http://www.aha.org/aha/content/2008/pdf/08-03-PolicyIdeasforChange.pdf

AHA Statement on the Importance of Clinical Integration to the Nation's Hospitals and their Patients, "Clinical Integration in Health Care: A Check-Up," May 29, 2008:
http://www.aha.org/aha/testimony/2008/080529-tes-ftc.pdf

AHA Letter to Christine Varney, Assistant Attorney General for Antitrust, Dept. of Justice, May 11, 2009: http://www.aha.org/aha/letter/2009/09-05-11-ltr-pollack-varney.pdf

AHA Paper: The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform, May 2009: http://www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf

Trendwatch: Clinical Integration – The Key to Real Reform, Feb. 2010:
http://www.aha.org/aha/trendwatch/2010/10feb-clinicinteg.pdf

Getting More from Health Reform – Five Barriers to Clinical Integration in Hospitals (and what to do about them), Mar. 2010:
http://www.aha.org/aha/content/2010/pdf/5barrierstoclininteg.pdf

Accountable Care Organizations: AHA Research Synthesis Report, June 2010:
http://www.aha.org/aha/content/2010/pdf/09-26-2010-Res-Synth-Rep.pdf

A Critique of Recent Publications on Provider Market Power, Oct. 4, 2010:
http://www.aha.org/aha/content/2010/pdf/100410-critique-report.pdf

"Clinical Integration: Linchpin of Real Reform," *Competition Policy International Antitrust Chronicle*. Oct. 20, 2010:
https://www.competitionpolicyinternational.com/clinical-integration-linchpin-of-real-reform/

Guidance for Clinical Integration (Updated) Working Paper, Sept. 2010:
http://www.aha.org/aha/content/2010/pdf/070417clinicalintegration.pdf

AHA Letter to Jonathan Blum, Deputy CMS Administrator Regarding Structuring Accountable Care Organization, Nov. 17, 2010:
http://www.aha.org/aha/letter/2010/101118-let-fishman-blum.pdf

Attachment C

Antitrust Letters from U.S. Senators

Letter from Senators Warner, Udall, Bennet, Burris, Kirk, Franken, Udall, Gillibrand and Hagen to DOJ and FTC, Dec. 23, 2009: http://www.aha.org/aha/letter/2009/091223-let-cl-FTC-DOJ.pdf

Letter from Senators Warner, Udall, Bennet, Burris, Kirk, Franken, Udall, Gillibrand and Hagen to GAO, Dec. 23, 2009: http://www.aha.org/aha/letter/2009/091223-let-cl-GAO.pdf

Letter from Senators Kohl, Leahy, Feinstein, Whitehouse and Specter to DOJ and FTC, Nov. 3, 2009: http://www.aha.org/aha/letter/2009/091103-let-clinical-integration.pdf

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Mr. JOHNSON. Thank you, Ms. Hatton.
Next, Mr. Lerner.

TESTIMONY OF ARTHUR LERNER, PARTNER, CROWELL & MORING LLP, ON BEHALF OF AMERICA'S HEALTH INSURANCE PLANS

Mr. LERNER. Chairman Conyers, Chairman Johnson, Ranking Member Coble, and Members of the Committee, I am Arthur Lerner partner in the Washington, D.C. office of the Crowell & Moring law firm. I am testifying today on behalf of America's Health Insurance Plans, a national association representing approximately 1,300 health insurance plans, providing coverage to over 200 million Americans.

I was very pleased to be invited to testify today by Chairman Conyers. After completing my undergraduate education at the University of Michigan, as did both of my parents and both my brothers and my wife—I only have one of those—and then attending law school, I began my legal career in 1976 in the Health Care Division of the Bureau of Competition as an antitrust trial attorney. I then worked as an assistant to the Director of the Bureau of Competition as attorney adviser to FTC Chairman Pertschuk from 1978 until 1981, as Deputy Assistant Director and then Assistant Director in charge of the FTC's Health Care Antitrust Program from 1981 to 1985 and have been in private practice since then. I am former Chair of the Antitrust Practice Group of the American Health Lawyers Association and of the Federal and Civil Enforcement Committee of the Antitrust Section of the ABA.

I am testifying today on behalf of AHIP and not on behalf of any other client or organization. And I am well aware of the history of antitrust enforcement in the health care sector, since that has been my life for the last 35 years. I appreciate this opportunity to testify in enforcement of our Nation's antitrust laws and the importance of preserving and expanding competition for the benefit of consumers.

I am going to talk principally about two things. My written statement goes on at somewhat greater length. First, antitrust enforcement to ensure competition in the health care provider community; and second, antitrust enforcement in the health insurance marketplace.

By way of introduction, I think the antitrust laws and antitrust enforcements do not and should not take sides, other than it being on the side of the consumer. Antitrust enforcement should not be and has not been for or against health insurance companies or for or against physicians or hospitals or any other industry. Whether an entity runs into antitrust trouble will and should depend on what it does.

On the physician side, the discussion today has seemed to focus on two things. One, whether physicians should be able to band together to sort of level the playing field and get a better deal for themselves. And I go into this at somewhat greater length in my statement. But it has never been a solid defense in the antitrust world to say, Well, I can't get paid the rate that I would like to be paid in the marketplace. Therefore, I should be allowed to fix prices to deal with that. That is a fundamental and blatant antitrust violation and has been viewed as such by Administration after Administration, by the courts through every Administration going back many, many years. On the other hand, if providers are

trying to get together and work to improve outcomes and to improve health care delivery, there is lots of room under the antitrust laws for them to do so today. And the FTC and DOJ have given out lots of guidance about how that can be done.

It is a difficult task sometimes to be in private practice, to advise clients, and I have advised clients that include not only health plans but also health care providers. When providers come and say, How much more of this integration stuff do I have to do so I can fix prices, it puts the lawyer in an awkward spot because the question then is not, How can I integrate; and if I integrate, what am I allowed to do along with that to make it work? But if the question is, How do we raise prices, if that is all it is about, then antitrust has a lot to say and properly so.

On the other hand, if what physicians and hospitals are trying to do is to actually expand and increase the quality of care to improve health care outcomes to be accountable for the costs, there is a lot of room for them to do so under the antitrust laws. Health plans are working across the country with many provider organizations in various kinds of projects both with organizations, you know, that are now being called accountable care organizations but for many, many years have taken other forms to try to improve health care and reduce costs.

There is always reason for the antitrust agencies to be up to date, for the antitrust agencies to look at the evolving marketplace and try to decide if clarification of their guidance is appropriate. But it would not be appropriate to radically alter the guidance that has been out there, so as either to permit blatant price fixing or to allow integration, which is, in a sense, a good thing to become sort of a talisman that allows providers to break the antitrust laws. There is room to do the former without having to do the latter.

On the hospital side, there are a lot of reasons for wariness and concern that we just make sure that hospital combinations and hospital consolidations do not raise inappropriate antitrust problems. The FTC and DOJ have been active in policing mergers in that area and need to be able to continue to do so.

Finally, on the health insurance side—I realize I have rambled through my time pretty quickly here, but I know that you are interested in hearing about health insurance and whether the antitrust laws should be enforced there. So if you let me, I will go on for another minute or so about that or I can wait and take it in questions.

Mr. JOHNSON. I think it might be good to let you go ahead.

Mr. LERNER. I will just talk briefly about it.

The Federal Trade Commission and the Department of Justice had a lengthy 27 days of hearings in 2004 and resulted in a conclusion that there is not a significant nationwide problem in terms of monopsony or power buying or health plans or paying providers less than what it costs to deliver health care. In fact, most health plans pay well more than the Medicare and Medicaid programs. There is data out there about concentration levels in health care. Some of that data is deeply flawed, the way it is counted, the way it is measured. But the most important thing to take note of is that the vigor of competition in some of these markets does not correspond with notions of, you know, what are the current shares.

Sometimes these markets are quite competitive, even if concentrated.

And the other thing I would probably want to emphasize today is that if you look at the mergers that have occurred in health care insurance plans, they typically do not account for whatever structure we now see in the health insurance marketplace. Typically it seems that companies who do the work better, have been better at it, have historically been large and significant in a local market are still the ones who are large and significant in a local market and that mergers have not typically involved the creation of the kind of structure that we are talking about. And I can say that when we have done mergers—and I have represented a number of clients—we get investigated extremely thoroughly and extremely acutely by Ms. Pozen's staff or the other people at the Department of Justice.

Sometimes these raise difficult questions, where a merger might involve the number eight competitor in a market merging with the number six competitor, where neither of them is going anywhere in particular, and the number one and two firms are very, very strong, so the Justice Department has to make some discerning judgments. So in our view, you know, every company always wants to think it is going to fare well. But my experience has been that the Department of Justice is quite thorough in their inquiries into health insurance mergers.

[The prepared statement of Mr. Lerner follows:]

PREPARED STATEMENT OF ARTHUR LERNER

Testimony

for

House Judiciary Committee

Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients

by
Arthur Lerner
Partner, Crowell & Moring LLP

December 1, 2010

I. Introduction

Chairman Conyers, Ranking Member Smith, and members of the committee, I am Arthur Lerner, partner in the Washington, D.C. office of the Crowell & Moring law firm. I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

I began my legal career in 1976 in the health care division of the Federal Trade Commission's Bureau of Competition as an antitrust trial attorney. I then worked as an assistant to the director of the Bureau of Competition, as attorney advisor to the FTC Chairman from 1978 to 1981, and as deputy assistant director and then assistant director in charge of the FTC's health care antitrust program from 1981 to 1985. Since 1985 I have been in private practice, first at a smaller firm, and since 2000 at Crowell & Moring, where I am co-chair of the Health Care practice. I represent health plans and insurers, hospitals, medical groups, charitable organizations and other clients in the health field. I am the former chair of the Antitrust Practice Group of the American Health Lawyers Association and of the Federal Civil Enforcement Committee of the Antitrust Section of the American Bar Association. I am testifying today on behalf of AHIP, and not on behalf of any other client or organization.

I appreciate this opportunity to testify on enforcement of our nation's antitrust laws and the importance of preserving and expanding competition for the benefit of consumers. Competition in the health care industry is critically important to promoting quality improvement, cost containment, consumer choice, and innovative approaches to health care delivery.

My testimony focuses on three broad topics:

- Antitrust enforcement to ensure competition among physicians and hospitals;
- Antitrust enforcement in the health insurance marketplace; and
- Health plan initiatives that are providing value to consumers.

By way of introduction, the antitrust laws and antitrust enforcement do not and should not take sides, other than being on the side of the consumer. Antitrust enforcement should not be and has

not been "for" or "against" health insurance companies, or physicians, or hospitals, or any industry. Whether any entity runs into antitrust trouble will and should depend on what it does.

II. Antitrust Enforcement With Respect to Physicians and Hospitals

Enforcement of the antitrust laws is necessary to protect and promote competition among health care providers, to help the nation achieve its goals of expanding coverage, improving quality, and containing costs. This is wholly consonant with, and an important value of antitrust independent of, health care reform legislation.

Physician Antitrust Issues

The two federal agencies with antitrust enforcement authority are the Department of Justice (DOJ) and the Federal Trade Commission (FTC). They have a long history of challenging price fixing, anticompetitive boycotts, and other suspect practices, by various parties and in various sectors of the economy. This reflects recognition by the antitrust laws, by the courts and by enforcement officials, that such practices almost always harm consumers by raising prices, reducing choice, and/or lowering quality. The actions of the DOJ and the FTC in this area with respect to physicians and other providers have been consistent with the *universal* condemnation of such practices no matter who commits them. As various stakeholders examine ways to "bend the cost curve," one area of general agreement should be that blatant price fixing, boycotts, and other behaviors that harm consumers should be prevented. Consumers are well-served by the agencies' longstanding enforcement posture against boycotts and price fixing, and this posture should continue in the future with respect to those who engage in such anticompetitive conduct.

This does not mean, however, that physicians and other providers are foreclosed from working together in ways that benefit consumers. In fact, just the opposite is true. Antitrust law has not been an impediment to physicians who want to engage in collaborations to improve health care quality or become accountable for the cost of care, and other activities that are beneficial to consumers. In fact, virtually no other portion of the economy has received so much guidance from the DOJ and the FTC on ways in which its participants can collaborate without violating the antitrust laws. Underlying such guidance, of course, are antitrust principles of general application. They have been illuminated in great detail in the form of antitrust health care policy statements, advisory opinion letters, and other agency materials discussing "financial integration," "clinical integration," and more generally helping market participants understand the variety of ways in which physicians and other providers can engage in collaborative activities

to benefit consumers. AHIP is confident that the agencies will continue to provide such guidance as new issues and questions arise.

Ultimately, the balance struck by the antitrust laws aligns exceptionally well with the goals sought by policymakers of virtually all views with respect to the health care system. Conduct that benefits consumers, through integration resulting in lower prices and/or higher quality, should be permitted in a manner that allows market participants to determine their own course and consumers and other purchasers to exercise choice. Anticompetitive conduct that harms consumers, through higher prices and/or lower quality, should be condemned. Some conduct can be plainly anticompetitive. Other activities must be evaluated in more depth to make an appropriate antitrust assessment. Still other activity, which of course predominates in the marketplace, raises no antitrust concerns at all. The posture of the antitrust agencies with respect to physicians and other providers reflects this careful, and appropriate, balance.

Hospital Antitrust Issues

As with most mergers, hospital mergers are regularly investigated by the DOJ and FTC. After some success in the 1980s, the agencies attempted to challenge several hospital mergers in the 1990s, but were unsuccessful in the courts. They are starting to have more success of late. This coincides with information from a variety of sources cautioning that provider combinations can in some instances have adverse effects and contribute to higher costs for consumers. These reports, supplemented by the evidence generated by the FTC's retrospective challenge of the *Evanston* hospital merger, reminds us that significant resources should be devoted to this area, to ensure that the goals of increased access, improved quality and cost containment are not undermined by anticompetitive combinations.

A November 2010 report[1] by the Center for Studying Health System Change (HSC), commissioned by Catalyst for Payment Reform, states: "Wide variation in private insurer payment rates to hospitals and physicians across and within local markets suggests that some providers, particularly hospitals, have significant market power to negotiate higher-than-competitive prices."

[1] Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power, by Paul B. Ginsburg, Center for Studying Health System Change, November 2010. Focusing on eight health care markets – Cleveland, Indianapolis, Los Angeles, Miami, Milwaukee, Richmond, San Francisco, and rural Wisconsin – the report found that the average inpatient hospital payment rates of four large national insurers ranged from 147 percent of Medicare rates in Miami to 210 percent in San Francisco. In extreme cases, some hospitals command almost five times what Medicare pays for inpatient services and more than seven times what Medicare pays for outpatient care. The HSC report also notes that variation in physician payment rates is not as pronounced as the variation in hospital payments.

Another report[2], issued in March 2010 by Massachusetts Attorney General Martha Coakley, focuses on health care cost trends and cost drivers in Massachusetts. A key finding was that price increases, not increases in utilization, caused most of the increase in health care costs during the past few years in Massachusetts.

A 2006 study[3], sponsored by the Robert Wood Johnson Foundation (RWJF) and performed by economists Robert Town and William Vogt, summarized the extent of hospital consolidation during the 1990s using the Hirschman-Herfindahl Index (HHI). This report found that, on average, the concentration of hospital ownership within metropolitan statistical areas (MSAs) increased by a substantial amount during the 1990s.

Other information, including from the antitrust agencies themselves, run parallel. For example:

- An FTC economist conducted a study of effects of the northern California transaction that brought Summit into the Sutter hospital system and determined that the merger resulted in previously lower Summit prices converging with those at Sutter's Alta Bates hospital. The study concludes that Summit's price increase post-merger was "one of the largest of any comparable hospital in California."

- The FTC found in the Evanston case that the analyses performed by **both** parties' expert economists "strongly supported the conclusion that the merger gave the combined entity the ability to raise prices through the exercise of market power." *See In the Matter of Evanston Northwestern Healthcare Corp.*

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[2] Massachusetts Health Care Cost Trends Final Report, Appendix B: Report Issued by the Office of the Attorney General Martha Coakley, March 2010. Other findings were that price variations in payments by health insurers to providers are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers and that higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume. Large health care providers have a great deal of leverage in negotiations because insurers must maintain stable, broad provider networks, according to the report.

[3] "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" RWJF Research Synthesis Report No. 9, W. Vogt and R. Town, February 2006. The authors stated:

> Over the 1990s the hospital industry underwent a wave of consolidation that transformed the inpatient hospital market place. By the mid-1990s, hospital merger and acquisition activity was nine times its level at the start of the decade . . . . In 1990, the typical person living in a metropolitan statistical area (MSA) faced a concentrated hospital market with an HHI of 1,576. By 2003, however, the typical MSA resident faced a hospital market with an HHI of 2,323. This change is equivalent to a reduction from six to four competing local hospital systems.

- A *Wall Street Journal* article reports substantial apparent price effects from a 1989 Roanoke hospital merger that the Department of Justice tried to prevent, unsuccessfully, in court. The article indicated that, "[n]early two decades [after the merger], the cost of health care in the Roanoke Valley – a region in southwestern Virginia with a population of 300,000 – is soaring. Health-insurance rates in Roanoke have gone from being the lowest in the state to the highest."

Concerns were also raised in the FTC and DOJ hearings that hospital systems in some instances may be using tie-ins, bundling, or other contracting or business practices to obstruct competition, stifle smaller competitors and prevent consumers and physicians from getting and acting upon timely information on cost and quality.

A recent report by Margaret Guerin-Calvert and Guillermo Israilevich from Compass Lexecon, commissioned by the American Hospital Association, is critical of reports that provider organization size and provider consolidation are the primary drivers of price. Ultimately, one need not accept the specific findings or methods of sources noted above to recognize that antitrust has an important and critical role to play. The Guerin-Calver & Israilevich report states that evaluations in this arena "should be based on sound economic principles and an examination of very specific facts and circumstances."[4] In this regard, it is important to stress that, as with other mergers, the great majority of hospital mergers are not problematic. Some can provide important benefits by fostering improved access to care, efficiencies and quality improvements. What is important is that the agencies remain on the lookout for those that are likely to harm consumers and have the resources to do so.

Sufficient resources should be devoted to the DOJ and FTC for investigations into hospital mergers and conduct when the facts warrant. They should examine, in particular, whether existing hospital systems have accumulated significant market power and are using it to stifle competition in hospital and other markets. Recognizing the need for such inquiries is not in deregation of the positive benefits that some hospital mergers can have. The key is to give the agencies the resources to make the necessary assessments to distinguish anticompetitive transactions from those that will have no such effect or will in fact be beneficial.

[4] "A Critique of Recent Publications Claiming Provider Market Power," M. Guerin-Calvert and G. Isreilevich at p. 38, October 2010

III. Antitrust Enforcement With Respect to Health Insurers

Health insurance plans operate in a very competitive industry, according to the DOJ and FTC. In their 2004 landmark report, the DOJ and FTC summarized 27 days of hearings exploring such issues as whether payors/health insurance plans possess monopsony (buyer-side) power in U.S. health care markets. Based on this in-depth exploration, the report concluded that the available evidence does not indicate that there is a monopsony power problem in most health care markets.[5] In addition, employer groups testified at those hearings that most Americans are served by health insurance markets with robust competition, with multiple insurers offering multiple product options.[6] This suggests that monopoly (seller-side) power is not an issue either. Others have cited data purporting to show that local health insurance markets are concentrated, in some cases with a single plan or a few plans having most of the enrollment. This data can be critiqued. More importantly, it is important to focus on whether high market shares, even when they do exist, are a reflection of market forces and consumer preference, or whether they are the result of anticompetitive mergers or anticompetitive behavior.

In this regard, mergers and acquisitions in the health insurance industry are thoroughly vetted by the DOJ. In addition to actively scrutinizing health plan mergers, the DOJ has required divestitures in cases where it concluded that overlap within a relevant product and geographic market warranted concern that anticompetitive effects would result. In one recent matter, it threatened to sue to block the merger altogether. The DOJ has not opposed health plan mergers when the available evidence indicated that the merging insurers were not close geographic competitors prior to the merger, where the merger would not harm competition overall or where the merger had the potential of making the market more competitive.

Critics have not identified mergers with direct geographic overlap posing potential risk of harm to competition from high concentration in properly defined antitrust markets that did not receive intense antitrust enforcement scrutiny. The DOJ's approach to geographic and product market definition is determined by the specific facts of each merger. While the DOJ commonly uses the metropolitan statistical area (MSA) as the relevant geographic market for assessing potential monopoly and monopsony harm in health plan merger investigations affecting typical employers and consumers, the DOJ in some circumstances also has assessed competitive effects within other relevant geographic markets. As the DOJ has explained, this approach recognizes that health insurers assemble networks of local physicians, hospitals, and other providers and then

[5] "Improving Health Care: A Dose of Competition," FTC/DOJ Report, 2004, chapter 2, page 21
[6] "Improving Health Care: A Dose of Competition," FTC/DOJ Report, 2004, chapter 6, page 7

market those networks to local employers and to consumers – so that the bulk of competition between insurers, both for customers and for providers, is predominantly local.

In some instances, the DOJ takes action to permit mergers only with divestiture of competing business operations. Indeed, over the past few years, the DOJ has challenged, or stated its intention to challenge, mergers involving UnitedHealthGroup and Sierra Health Services, UnitedHealth Group and PacifiCare, and Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan. The first two cases were settled, with divestitures required by the merging parties to address the competitive issues raised. In the United-Sierra matter, for example, the DOJ required a divestiture remedy to protect enrollees in Medicare Advantage plans. In the United-PacifiCare matter, the DOJ focused on harm to competition both in the sale of health insurance and in the purchase of physician services. The Michigan transaction was abandoned after the DOJ stated its intention to challenge the merger. Other mergers have been investigated intensively, before DOJ closed the inquiry without action, apparently because the DOJ found the transaction was not likely to harm competition. Depending on the transaction, the DOJ's focus may be on small group customers, on Medicare beneficiaries, on purchasers of fully insured (rather than self-insured) products, on the impact of the merger on physicians or other providers, or on other discrete segments of the marketplace. From my own experience, that scrutiny can be sharp and exceptionally acute. Without commenting on the merits of any particular transaction, the DOJ's activities in this area reflect an active merger enforcement program, focused on identifying those mergers that, on the evidence, it believes should be challenged. It seeks the remedies it believes will protect consumers.

This enforcement activity by the DOJ is complemented by parallel scrutiny of health plan acquisitions by state attorneys general and insurance commissioners. They too have taken a number of enforcement actions. A recent briefing document available from the American Health Lawyers Association provides a useful inventory of antitrust and competition investigations and actions involving health insurer mergers.[7]

There also have been conduct investigations and enforcement with respect to health insurers. Over the years, agency testimony has detailed numerous investigations and enforcement actions with respect to health insurance. The DOJ currently has a case filed in federal court related to the purported anticompetitive use of most favored nations (or MFN) clauses by a health insurer. This is a continuation of agency practice in challenging MFN clauses in certain market

[7] "Evaluating Federal and State Antitrust Reviews of Health Insurance Mergers," American Health Lawyers Association Antitrust Practice Group Member Brief, August 2010.

circumstances. More generally, it is a continuation of agency practice in actively investigating both mergers and conduct in health insurance markets.

IV. Health Plan Initiatives That Provide Value to Consumers

Competition in the health insurance marketplace is helping to drive innovative programs by insurers to make their products more appealing to consumers and employers. These include:

- targeting disease management services for enrollees who stand to benefit the most from pro-active interventions;
- working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- providing incentives to promote the use of decision-support tools and health information technology;
- providing quality improvement reports for physicians to monitor their progress in managing disease;
- offering personalized risk assessments and wellness programs;
- encouraging electronic prescribing and consumer safety alerts; and
- providing peer-to-peer comparisons to demonstrate the appropriate use of health care services across specialists and manage the use of high-cost services, such as high-tech imaging services.

Other health plan initiatives focus on administrative simplification to improve the flow of information between clinicians and plans, payment reforms that reward quality and promote evidence-based health care, and performance measures to provide consumers better information about quality and costs.

Administrative Simplification

Through a partnership with the Council for Affordable Quality Healthcare (CAQH), many AHIP members are participating in an initiative, known as CORE, that has focused on developing a single set of operating rules to expand and enhance the standards for administrative transactions in the health care industry. The goal of these rules is to streamline and automate the claims payment cycle by encouraging interoperability between health plans and providers.

The CORE collaboration started in 2005 and approximately 115 entities are now participating. Participants include health insurance plans, providers and provider groups, health IT companies,

standard setting organizations, federal and state agencies, and other health industry trade associations. Once the CORE initiative is fully implemented, the operating rules will enable all administrative transactions to be performed electronically. All parties will be able to exchange information in a consistent, predictable manner – ensuring that clinicians have the information they need on any patient, covered by any insurance, when they need it. This is comparable to the standards work that was done to allow banks to offer ATMs to consumers. This initiative also lays the groundwork that will enable the administrative simplification provisions of the new health reform law to work.

Physician Portals

Building on the development of common standards, it is my understanding that AHIP and the Blue Cross and Blue Shield Association (BCBSA) are working with their members in New Jersey and Ohio where state-based initiatives have been launched to simplify the flow of information between health plans and physicians' offices. These initiatives allow physicians to use a single web portal to conduct electronic transactions with all of the health insurance plans that insure their patients, helping them to streamline and fully automate key office tasks.

Payment Reforms

Health insurance plans also have implemented innovative payment models to reward quality and promote evidence-based health care using clinical guidelines. When properly applied, evidence-based clinical guidelines allow doctors to do what they were trained to do while reducing the chance of undertreatment, overtreatment, and mistreatment. For patients, these initiatives can mean greater safety and improved outcomes. Providers can be recognized and rewarded for practicing to the highest professional standards.

Improving Performance Measures

The health plan community is working to provide patients more reliable information on health care quality and costs. Through the AQA Alliance, AHIP has participated in multi-stakeholder efforts to improve and make more consistent the measures by which provider quality are assessed and implemented by the public and private sectors.

This coalition, which includes private groups like the American Academy of Family Physicians and the American College of Physicians, as well as the Agency for Healthcare Research and Quality (AHRQ), has as its goal the development of consensus processes for implementing performance measurement and reporting. Its processes would: (1) allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and (2) enable practitioners to determine how their performance compares with their peers in similar specialties. This effort

includes more than 135 organizations, including consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, health insurance plans, and government representatives.

The AQA, among other things, has implemented a pilot program in six sites across the country, with support from the Centers for Medicare & Medicaid Services (CMS) and AHRQ. These pilots, known as the Better Quality Information or BQI sites, combined public and private sector quality data on physician performance.

V. Conclusion

Thank you for allowing me this opportunity to testify on behalf of AHIP. The health plan community looks forward to continuing to work with the Committee and the antitrust agencies to promote and preserve competition with the goal of further expanding access to high quality, affordable health care.

Mr. JOHNSON. All right. Thank you, Mr. Lerner. I am anxious to determine whether or not your extensive contacts with the State of Michigan will save you from the heat that I expect to be generated.

Mr. LERNER. I am actually from Toledo, so we paid out-of-State tuition for 12 years without my brother.

Mr. JOHNSON. All right. Thank you, sir.
Dr. Mandell.

TESTIMONY OF PETER J. MANDELL, M.D., CHAIR OF THE COUNCIL ON ADVOCACY, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dr. MANDELL. Chairman Conyers, Chairman Johnson, distinguished Members of the Committee, thank you for having me here this morning. I am Pete Mandell, Chair of the Council on Advocacy of the American Association of Orthopaedic Surgeons. I am also a practicing orthopedist on the San Francisco Peninsula and have done that for about 35 years now. On behalf of our organization and my orthopedic surgeon colleagues across the country, thank you for inviting us to talk about antitrust laws as interpreted by the U.S. Department of Justice and the Federal Trade Commission and their effects on patients and physicians.

As we talked about all morning, health insurance markets are highly concentrated; and for the most part insurers possess market shares that are associated with monopsony power, the ability to present physicians with take-it-or-leave-it contracts that harm the quality and supply of physician services in this country. Moreover, because health insurers are virtual monopolies, whatever savings are generated by those take-it-or-leave-it contracts are not provided to the beneficiaries of their insurance, also known as our patients.

Because of these indisputable facts, AAOS believes that the antitrust laws should be changed to allow physicians to collectively negotiate with health plans and that the McCarran-Ferguson Act should be amended to change the anti-competitive practices of insurance companies and establish negotiating equity among health plans and physicians. The fact that health insurers possess monopsony power and the physicians are powerless in their negotiations with health plans should not be news to anyone. For a decade now, the AMA has provided studies that report that unequivocally, physicians across the country have virtually no bargaining power with dominant health insurers, and those health insurers are in a position to exert monopsony power.

Antitrust enforcement by the DOJ and FTC has been ineffective in halting health insurer market concentration. However, it has been effective in preventing physicians from jointly negotiating with insurers. In this way, antitrust enforcement has actually augmented the negotiating power of insurers. Physicians, we think, should be allowed to share information and negotiate collectively with health insurance plans.

Currently, the DOJ and FTC allow a restrictive form of bargaining that we talked about a little while ago called the third-party messenger model which has been used with only spotty success around the country. It is labor-intensive, cumbersome, and costly to implement safely. It has also proven an easy target for insurers because they know that the DOJ and FTC have a low threshold for alleged physician collusion and for initiating expensive antitrust investigations and litigations.

Let me give you two examples. In Delaware, a dozen years ago, a health insurance plan unilaterally instituted massive cuts. Almost all the 47 orthopedic surgeons and many other physicians in

that State dropped out of the plan. The physicians negotiated, using a union and using the third-party messenger model. While the insurer reversed the cuts, the DOJ ultimately investigated and prosecuted the physicians and the union. Approximately 80 subpoenas were issued. Depositions were taken in four States. The union itself incurred about $1.5 million 1998 dollars in legal fees. It is more like $2 million now. In the end, the consent decree allowed the use of the third-party messenger model anywhere in the United States except for Delaware and by anyone in the United States except for that union for a period of 5 years. One orthopedic surgeon colleague lost his partnership in a medical practice. Another was threatened with imprisonment by the DOJ.

The second example involves a case that was finalized earlier this year in Idaho where the Idaho Orthopedic Society and other orthopedists were charged by the DOJ with antitrust violations. Although resolved by consent decree, the defendants incurred more than $1 million in legal fees and expenses. Several Idaho colleagues report that the final decree bears no resemblance to the actual events that went on in Idaho, which they found quite frustrating. For example, at no point during the investigation were the accused physicians interviewed or deposed.

Antitrust laws send a clear message of what fair competition means—or should send a clear message of what fair competition means. Instead, the message we hear, as physicians, loud and clear is the Hobson's choice of "just lie down and take it." If physicians object, they are exposed to charges of antitrust violation.

This is why the AAOS supports legislation like the Quality Health Care Act of 2000, sponsored by Congressman Conyers and former Congressman Tom Campbell. Such an act would extend to all health care providers—not just doctors, but all health care providers—the right to collectively negotiate with health insurance companies.

AAOS supports the Subcommittee's efforts to address the issue of equal application of antitrust laws to both physicians and health insurance plans.

AAOS is pleased to have had the opportunity to share with you our thoughts but, more importantly, the experiences of our colleagues on the effects of DOJ and FTC antitrust enforcement. Maintaining quality care while ensuring fair competition in today's market should be our ultimate goal, and we thank you for giving us the opportunity to present this morning and look forward to working with you further on this in the future.

[The prepared statement of Dr. Mandell follows:]

Statement

of

Peter J. Mandell, MD
Chair, Council on Advocacy
American Association of Orthopaedic Surgeons (AAOS)

on

Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients

Presented to the
Committee on the Judiciary
The Subcommittee on Courts and Competition Policy
U.S. House of Representatives

December 1, 2010

Statement

of

Peter J. Mandell, MD
Chair, Council on Advocacy
American Association of Orthopaedic Surgeons

Presented to the

Committee on the Judiciary
The Subcommittee on Courts and Competition Policy
U.S. House of Representatives

Antitrust Laws and Their Effects
On
Healthcare Providers, Insurers and Patients

Good morning, Chairman Johnson, Ranking Member Coble, and other distinguished members of the subcommittee. I am Dr. Peter Mandell, Chair of the American Association of Orthopaedic Surgeons (AAOS) Council on Advocacy. I'm an orthopaedic surgeon in private practice on the San Francisco peninsula and have been doing that for over 35 years now. On behalf of the AAOS and my orthopaedic surgeon colleagues across the country, thank you for inviting our organization to testify before you today on the enforcement of antitrust laws against physicians by the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC).

Overview

Health insurance markets are highly concentrated and for the most part insurers possess market shares that are associated with monopsony power – the ability to present physicians with "take it or leave it" contracts that harm the quality and supply of physician services. Moreover, because health insurers are monopolists in the sale of insurance, they bear no loss of business consequence for the reduced physician services their beneficiaries endure.

The Quality Health Care Coalition Act, introduced by Congressman John Conyers and former Congressman Tom Campbell almost 12 years ago, would have leveled the playing field in the contract negotiations between physicians and insurers. AAOS continues to support this type of important legislation.

Physicians should be allowed to share information and negotiate collectively with health insurance plans. Right now the DOJ/FTC allow a restricted form bargaining called the third party messenger model. But this model has been used with only spotty success because it is labor intensive, cumbersome and costly to implement safely. It has also

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proven an easy target for insurers and the DOJ/FTC have a low threshold for alleged physician 'collusion' and for initiating expensive antitrust investigation/litigation.

AAOS believes:

- The antitrust laws should be changed to allow physicians to collectively negotiate with health plans and insurers without necessarily joining a labor union; and

- The McCarran-Ferguson Act must be amended to change the anti-competitive practices of insurance companies and establish negotiating equity among health plans, insurers, and physicians.

AAOS also supports the AMA's position on Accountable Care Organizations (ACOs) and the enactment and promulgation of regulations to ensure physician's continued ability to provide quality patient care.

Background
The fact that health insurers possess monopsony power and that physicians are powerless in their negotiations with health plans should not be news to anyone. The AMA's study, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2007)*, reported that "unequivocally … physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power."[i] The 2009 AMA report found that in 18 of 42 states, the two largest insurers had a combined market share of 70 percent or more. In one year, the two largest insurers with a combined market share of 70 percent or more increased from 18 of 42 states to 24 of 43 states, according to the AMA's 2010 report.[ii] One other antitrust author noted that Blue Cross Blue Shield of Michigan has had "market dominance for decades."[iii]

Examples of Enforcement Against Physicians
Antitrust enforcement has been ineffective in halting health insurer market concentration. However, antitrust enforcement has had the effect of preventing physicians from jointly negotiating with insurers. In this way, antitrust enforcement has actually augmented the negotiating power of insurers, as was demonstrated in Delaware.[iv]

There, an insurance company mailed physicians a notice advising that if they failed to respond in 30 days, those physicians gave up the right to change the terms of the contract. While most physicians responded within the 30 days, several of my Delaware colleagues recall that the insurer instituted massive rate cuts anyway. Soon thereafter many physicians in Delaware, including most if not all of the 47 orthopaedic surgeons practicing in Delaware, dropped out of the plan.

The physicians negotiated with the insurer in good faith through the Federation of Physicians and Dentists, using the third party messenger model. The insurer reversed the cuts, but the physicians believe that the insurer then contacted the DOJ to make

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allegations of antitrust violations. Approximately 80 subpoenas were issued and the Federation itself incurred $1.5M in legal fees. Depositions were taken in Florida, Ohio, Connecticut and Delaware. At least two of my colleagues believe that that their phones were electronically monitored throughout the process.

The end result was that the consent decree allowed the use of the third party messenger model anywhere in the U.S. but not in Delaware, and definitely not by the Federation for a period of five years. One of my colleagues lost his partnership in a practice. Another colleague was threatened with imprisonment by the DOJ. In his negotiations with the insurance plan, he found the third party messenger model to be wholly ineffective, as the insurance company refused to recognize it.

The most recent enforcement action occurred in Idaho this year, when the Idaho Orthopaedic Society, an orthopaedic practice group and five individual orthopaedic surgeons were charged with antitrust violations.[v] The action was resolved with a consent decree, after the defendants incurred more than $1M in legal fees and expenses. Several Idaho colleagues report that the final decree bears no resemblance to what actually happened in Idaho, which they find frustrating. For example, at no point during the investigation were the accused physicians interviewed or deposed.

Antitrust laws should send a clear message of what fair competition means. Instead, the message physicians hear loud and clear is the Hobson's choice of "Lie down and take the contract the insurance companies give you." If physicians object, they are exposed to charges of antitrust violations.

As practicing physicians, my colleagues and I can see the inequities of the current antitrust laws played out on an almost daily basis around the country. Particularly for solo practitioners like me, attempts to negotiate with insurance monopolies seem truly impossible.

Half a decade ago in California, Blue Cross joined with the State Compensation Insurance Fund to jointly control what was then about half of the Workers' Compensation market in the state, and a large portion of private group health coverage as well. The state workers' compensation fund forced physicians to contract with Blue Cross' networks, and in turn, Blue Cross forced those physicians to accept all of the plan's products or be dropped completely from its network of over 300 affiliates.

The combination of these two systems allowed Blue Cross of California to demand below cost reimbursements and to use their market power to artificially drive down rates. Physicians' actual cost of providing the care was not a consideration. California physicians brought this matter to the DOJ and FTC. They investigated but took no action.

Recommendations

AAOS supports legislation like the Quality Health Care Coalition Act of 2000, sponsored by Congressman Conyers and former Congressman Tom Campbell. Such an act would

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extend to all health care professionals (not just physicians) the right to collectively negotiate with health insurance companies. These collective negotiation rights would not extend to Medicare, Medicaid, or to hospitals, and would not grant healthcare providers the right to strike. However, the right to collectively negotiate without the necessity of a union is essential.

AAOS also supports the American Medical Association's position on antitrust enforcement as it relates to Accountable Care Organizations (ACOs).[vi] As Cecil B. Wilson, MD, AMA President, explained last month at the FTC Antitrust Workshops, the American health care system has evolved far beyond the marketplace envisioned when the *Statements of Enforcement Policy in Health Care* were jointly developed by the DOJ and FTC in the 1990s.[vii] The current interpretation of our antitrust laws, enacted to protect the smaller competitor from the larger and stronger one, are now having the opposite effect, ultimately negatively impacting patient care. This climate presents multiple conflicts for the development of ACOs.

The AAOS supports the development of Accountable Care Organizations (ACOs), and the coordination of federal laws. As the FTC Workshops addressed, there are many statutes and regulations at play, including antitrust, Medicare and Medicare, anti-kickback, fraud and abuse, and Stark laws. The complexity of this issue, however, should not be a deterrent; the goal is a worthy one. "This is where the intersection between ACO formation, antitrust enforcement policy and the nation's fraud and abuse laws occurs and where legal barriers must be lifted," Dr. Wilson said. AAOS agrees with Dr. Wilson and supports the enactment of the necessary legislative and regulatory measures to ensure that physicians retain the ability to provide quality patient care.

Conclusion

The American Association of Orthopaedic Surgeons supports the Subcommittee's efforts to address the issue of equal enforcement of antitrust laws and their application to physician negotiations with health insurance plans. AAOS is pleased to have had the opportunity to share with you our thoughts, but more importantly, the experiences of our colleagues with DOJ and FTC antitrust enforcement actions. Maintaining quality patient care while ensuring fair competition in today's marketplace must be the ultimate goal.

On behalf of the AAOS, I would like to thank the Chair, the Ranking Member, and the entire subcommittee for your interest in and attention to this important issue facing America's patients and their physicians. We look forward to continuing to work with you on this matter.

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[i] American Medical Association, *Competition in Health insurance: A Comprehensive Study of U.S. Markets (2007)* at 5.

[ii] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2010).*

[iii] Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook, p.42 (Thomson West 2007).

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[iv] *USA v. Federation Of Physicians And Dentists, Inc.*, final Order available at http://www.justice.gov/atr/cases/f200600/200654.htm

[v] *USA and Idaho v. Idaho Orthopaedic Society, Idaho Sports Medicine Institute, Doerr, Hessing Kloss, Lamey, and Watkins*, final Order available at http://www.justice.gov/atr/cases/f262000/262061.htm

[vi] **Resolved**, that the American Association of Orthopaedic Surgeons shall work in concert with the American Medical Association and other appropriate organizations to promote legal mechanisms to allow physicians to engage in group negotiations with third party insurers. 2008 AAOS Resolutions, Collective Bargaining Issues, R1998B1, Adopted 1998; retained 2003 and 2008.

[vii] Cecil B. Wilson, MD, AMA President, Oct. 5, 2010, Workshop Regarding Accountable Care Organizations and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback and Civil Monetary Penalty Laws, Baltimore, Md.

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Mr. JOHNSON. Thank you, Dr. Mandell.

Next, Dr. Connair.

TESTIMONY OF MICHAEL P. CONNAIR, M.D., AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO

Dr. CONNAIR. My name is Dr. Michael Connair. Thank you for this honor. And thank you, Peter, for your comments, with which I agree.

Mr. JOHNSON. And if you would pull that microphone up. Is it on?

Dr. CONNAIR. It is not on.

Mr. JOHNSON. There is a button down there.

Dr. CONNAIR. I am an orthopedic surgeon in solo practice in Connecticut, and I am the Vice President of the National Union of Hospital and Health Care Employees and the Federation of Physicians and Dentists, both are affiliates of AFSCME. I speak to you this morning as a physician and from a labor union perspective.

Unions represent the largest block of organized consumers in the Nation and have a significant stake in the quality of health care. Too often, the quality has been compromised because insurers, rather than physicians, inappropriately dictate the care a patient receives. Contracts between insurers and physicians of course regulate reimbursement for physicians but, more importantly for consumers, greatly affect the quality and availability of care that we, physicians, provide for our patients every day.

For the past 14 years, my unpaid union role has been to educate physician members in lawful ways to obtain fairer contractual terms from insurers. Physicians in three of the groups that I helped organize, alluded to by Dr. Mandell, were sued by the Department of Justice for alleged antitrust violations despite Herculean efforts to follow the third-party messenger model outlined by the DOJ FTC. The doctors in these three groups had simply refused to be coerced into contracts that would have resulted in a 20 percent or more decrease in reimbursement. The contractual relationship of doctors to insurers is similar to the weak position that unorganized service workers face when they are up against an employer intent upon maximizing profit.

There is much more at stake though in physician insurance contracts than physician finances. Bad contracts give insurers the legal right to limit care and impose substandard care on patients. As a practical matter, insurers possess monopsony power in virtually all U.S. markets, and doctors have no choice but to participate in these contracts or go out of business.

The ability of a physician to obtain a fair contract from an insurer grows more difficult every year. A lack of antitrust enforcement against insurers and prosecution of about 35 cases against physicians have made insurers downright dictatorial in their treatment of physicians and patients.

This is a stack of 33 of the 35 cases either description or consent decree. Typically, these cases are about physicians seeking to unfix insurance company price fixing. Insurance consolidation and the Federal antitrust enforcement pattern has had a chilling effect on physicians' willingness to resist substandard provider agreements

either for their own financial survival or to protect the quality of patient care. The unprecedented antitrust enforcement has allowed insurers to intimidate physicians into accepting low fees or even giving up the practice of medicine altogether.

There is a pressing need to grow the ranks of primary care providers, but insurance company practices are inhibiting this growth by undervaluing the work of these doctors, often paying them less for a visit than a plumber or a vet.

When it comes to physicians and patients, insurers act with impunity because they perceive they have immunity. Insurance companies get a free pass on antitrust with respect to physicians and a free pass from patient lawsuits under ERISA.

Health care benefits are provided in lieu of additional wages. Unopposed monopoly pricing of insurance products robs workers and employers of value. When a third of health care dollars are diverted away for patient care, workers are shortchanged.

A false semblance of market stability results when intimidated doctors stop fighting and begin signing substandard contracts. The one-sided antitrust prosecutions and forced consent decrees are always, always against doctors and never—not once in the history of the U.S. that we can find, and they are often unfair and incomplete.

Some blame goes to the courts. Federal judges are mandated by the 2004 amendments to the Tunney Act to review antitrust consent decrees for fairness and impact on the public. This is not routinely done, and it has been discouraged by the DOJ. During the debate on the 2004 amendments, then Chairman Sensenbrenner commented that the amendments were to ensure judicial review beyond "the mockery of justice standard."

True health care reform requires antitrust reforms; that is, a rebalancing of the contractual power between doctors and insurers so that patients are guaranteed access to the best medical care. Antitrust legislative reforms must include a reconsideration of the right of physicians to collectively negotiate with payers, as proposed by Campbell and Conyers. Antitrust regulatory reforms must include an update of the 1996 antitrust guidelines consistent with current market realities and the right for physicians to develop and participate in quality initiates without threat of prosecution.

And finally, antitrust enforcement reforms must start and end with an even-handed application of the rules of competition by the DOJ and the FTC, consistent with the intent of the 1890 Sherman Act. That includes independent review of the last 35 consent decrees for fairness. The Sherman Act, you will remember, was written as a short and general outline of fairness principles with the expectation that regulators and the courts would tailor the details to the specific market situations. Current antitrust enforcement in health care fails to treat physicians and consumers fairly.

I would like to thank Chairman Conyers, Chairman Johnson, Ranking Member Coble, and Members of this Subcommittee and their staff for holding this hearing. I will be pleased to answer any questions.

[The prepared statement of Dr. Connair follows:]

PREPARED STATEMENT OF MICHAEL P. CONNAIR

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Testimony of Michael P. Connair, M.D.
Vice President

Of the

Federation of Physicians and Dentists (FPD)

And of the

National Union of Hospital and Healthcare Employees (NUHHCE)

Affiliated with

American Federation of State, County and Municipal Employees (AFSCME)

Before the

U.S. House of Representatives Committee on the Judiciary

Subcommittee on Courts and Competition Policy

For the hearing on

Antitrust Laws and Their Effect on Health Care Providers, Insurers and Patients

December 1, 2010

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Thank you Mr. Chairman and distinguished members of the Subcommittee for inviting me to testify today. I am Dr. Michael P. Connair, a solo practitioner of orthopedic surgery in Connecticut, past president of the Connecticut Orthopaedic Society, member of the Connecticut State Medical Society, the American Academy of Orthopaedic Surgeons, the American Medical Association, and the Vice President of the Federation of Physicians and Dentists and the National Union of Hospital and Healthcare Employees (NUHHCE) which are affiliated with the American Federation of State, County and Municipal Employees (AFSCME, AFL-CIO). I trained at Harvard Medical School and its affiliated hospitals and am now an Assistant Clinical Professor of Orthopaedics at Yale. My clinical practice includes caring for private patients insured by commercial and government insurers and taking care of the orthopedic needs of children served by the Spina Bifida Clinic at Yale New Haven Hospital.

My unpaid union role for 14 years has been to educate physicians about the lawful procedures necessary to obtain fairer contractual terms from commercial health insurers, consistent with the 1996 Department of Justice/Federal Trade Commission (DOJ/FTC) *Statements of Antitrust Enforcement Policy in Health Care*. These contracts between insurers and physicians, so-called provider agreements, regulate not only the reimbursement that physicians receive, but greatly affect the quality of medically necessary care that physicians are allowed to provide for patients. Physician members of three of the groups that I helped organize were subsequently sued by DOJ for alleged antitrust violations, despite Herculean efforts to follow the cumbersome third-party messenger model outlined by DOJ. (See Reference Notes 1, 2 and 3.) The physician members of these three groups had simply refused to be coerced into contractual arrangements that would have resulted in a 20% or more decrease in reimbursement. Many doctors were threatened by the insurers with contract termination for refusal to accept their unilateral demands.

I fully support and agree with the earlier testimony today of my orthopedic colleague Dr. Peter Mandell and want to make several additional points from the perspective of a labor union vice president who practices medicine. (Reference Note 4.)

Union members have a significant stake in health care, because unions represent the largest block of organized consumers in the nation. Unions also sponsor health plans through funds that are jointly-trusteed with management. And of course, many union members,

including myself, work in the health care industry and rely on help with employment contract negotiations.

Quality of care always has been a primary concern for the labor movement. Working families frequently give up wage increases in order to maintain their health care coverage. Unions bargain to ensure that coverage for working families will actually provide the care they need when they get sick. Too often, the quality of coverage does not meet this test because insurance companies, rather than physicians, inappropriately dictate the care a patient deserves and ultimately receives. If harm occurs to a patient because of an administrative decision by an employer-funded ERISA insurance plan, the insurer cannot be sued for damages caused by cutting corners to increase profits. Physicians are often powerless to insist upon the best care, yet can be held responsible if a bad outcome occurs.

The contractual relationship of individual physicians to a commercial health care insurer is similar to the weak position that unorganized service workers face against an employer that unilaterally provides unfair wages and poor working conditions in order to maximize profit. There is much more at stake in a one-sided physician-insurer "provider agreement" than physician finances. Health care quality and access are impacted by a bad provider agreement. Bad contracts give insurers the legal "right" to limit care and impose substandard care on workers and all consumers. As a practical matter, insurers possess monopsony power as the purchaser of physician services in virtually all U.S. markets and doctors have no choice but to participate in these contracts. Even if a physician could afford to drop out of these contracts, patients usually cannot afford to pay for physician services out-of-pocket. I have actually stayed in bad plans at the request of valued patients with whom I have an established relationship – as a powerless solo practitioner, what else can I do?

I outlined some of the most egregious contractual terms that adversely impact patient care in oral and written testimony to the full House Committee on the Judiciary in 1998 in support of the "Quality Health-Care Coalition Act of 1998" (H.R. 4277), legislation sponsored by former Rep. Tom Campbell and later also by Chairman Conyers. (Reference Note 5.) This legislation would have allowed physicians to collectively bargain all contractual terms with insurers including those provisions that affect the quality of patient care. These harmful contractual terms include:

- Contracts that discourage appropriate specialty care;
- Unreasonable administrative barriers to prompt and reasonable care;
- Forcible separation of patients from trusted physicians;
- Low paying contracts which result in high volume but lower quality care;
- Capitation schemes which pay physicians not to treat patients; and
- Contracts that can be unilaterally modified by the insurer without negotiation.

The ability of a physician to ask or demand a fair contract from an insurer has deteriorated further since the 1998 hearings on H.R. 4277. Since then, a lack of antitrust enforcement against insurers and more than 30 cases against physicians has made insurers downright arrogant in their treatment of physicians and patients. The DOJ/FTC antitrust enforcement pattern with respect to the physicians-insurer contracting process has had a chilling effect on physicians' willingness to resist substandard provider agreements either for their own

financial survival or to protect the quality of patient care and the access to care. David Balto, former Director for Policy and Evaluation in the FTC's Bureau of Competition, commented on the economic impact of the 31 such physician cases brought by the DOJ and FTC between 2000 and 2008. He said the "Bush Administration spent a disproportionate amount of resources on physicians – bringing 31 cases... These enforcement actions may have resulted in many enforcement actions without much benefit to consumers or impact in the market." (Reference Note 6.) But Mr. Balto was referring to pricing and did not consider the negative cumulative impact that repeated legal assaults on physicians have had on the availability of primary care physicians. The unprecedented use of antitrust enforcement has augmented insurer bargaining power and ability to intimidate physicians into accepting low fees or even ceasing to practice medicine. As monopolists, these same insurers suffer no loss of business for diminishing the availability or quality of important medical services.

Since 1997, the Federation of Physicians and Dentists, NUHHCE and AFSCME have worked extensively to level the playing field for physicians with respect to their employment relationship with insurers. Much of that effort has been devoted to defending doctors against antitrust allegations made by insurers; DOJ responds to insurance company complaints against physicians with costly subpoenas, depositions and consent decree negotiations. The legal costs for physicians to defend themselves against a DOJ or FTC investigation or prosecution are so punitive that physicians sign humiliating consent decrees simply to avoid a trial. During the DOJ antitrust case against the orthopedists of Delaware in 1998, the legal defense costs to deal with approximately 20 depositions and 80 subpoenas and the negotiation of a consent decree totaled $1.5 million, and that was without a trial!

The labor movement is also greatly concerned about skyrocketing costs aggravated by monopoly and oligopoly pricing of insurance products in many markets. Antitrust enforcement efforts with respect to insurance company mergers and acquisitions by federal and state agencies have been tepid at best. The recent DOJ litigation against Blue Cross of Michigan was newsworthy in part because such actions are infrequent. Consider my own State of Connecticut, where the number of health insurers has dwindled from eight to only three or four insurers depending on a patient's geographic location in the State. Most recently, UnitedHealthcare acquired HealthNet, but DOJ and the FTC did not review the merger – simply letting these enormous national insurers get bigger under the false premise that some economies of scale would funnel down to patients. Well, in Connecticut, with the extreme premium rate requests, we have not seen those economies of scale – although the insurer profit margins have increased.

Like many health care policy makers in Congress, the labor movement agrees that there is a pressing need to grow the ranks of primary care providers. But insurance company practices are inhibiting this growth by undervaluing the work of these doctors. By failing to adequately compensate primary care physicians, the industry is driving doctors into specialties that will provide an adequate return on the educational investment and time needed to become a doctor. Primary care physicians are often paid less for an office visit than a plumber or veterinarian. Dedication alone will not pay office overhead, malpractice insurance premiums and medical school debt.

Some primary care physicians, sick of fighting insurers, give up private practice and become hospital employees. This trend is not always in the best interest of patients whose health care needs do not always align with the hospital's financial needs. Employed physicians may not

be able to advocate as effectively for patients if care decisions might threaten job security. Allowing hospitals and health systems to get larger is not the answer either, as this could also lead to increased control by a few select entities large enough to dictate pricing and unfairly compete with independent physicians and privately owned ancillary facilities.

Health care benefits are part of a worker's overall compensation provided in lieu of additional wages. Unopposed monopoly/oligopoly pricing of insurance products robs workers and employers of value. When one-third of health care dollars are diverted away from patient care, workers are shortchanged. DOJ and the FTC have done little to control the consolidation of the insurance industry into fewer and larger insurers with increasing market influence.

For example, for many years in the Philadelphia, Pennsylvania metropolitan area, there have been only two insurers. Annual double digit premium increases are routine, in some cases as high as over 50%. As a result, low-income hospital workers covered by one multi-employer fund faced with such increases have agreed to forego negotiated wage increases in order to assist their employers in paying for increased premiums.

A false semblance of market stability results when physicians sign substandard contracts without a fight. The one-sided antitrust prosecutions and forced consent decrees, always against doctors and *never* against insurers, are often highly unfair, especially when the policing efforts of DOJ lack adequate oversight by the courts. Often the insurance company contractual demands that caused physicians to revolt in the first place are not set forth in the consent decree. Dr. Mandell, in his testimony today, refers to the onerous Idaho consent decree. A description of the insurance company activities precipitating the Delaware and Cincinnati cases are not included in those consent decrees.

Federal judges are mandated by the 2004 amendments to the Tunney Act to review antitrust consent decrees for fairness and impact on the public. This is not routinely done. In public remarks made on February 28, 2007, Jay L. Himes, then-Chief of the Antitrust Bureau in the Office of the New York Attorney General, stated that the Tunney Act was amended in 2004 to ensure that the courts "undertake meaningful and measured scrutiny of antitrust settlements to ensure they are truly in the public interest..." (Reference Note 7.) During debate on the 2004 amendments, then-Chairman F. James Sensenbrenner commented that the amendments were to ensure judicial review beyond the "mockery of justice" standard. In the Senate, Senator Mike DeWine stated that "mere rubber-stamping [of consent decrees] is not acceptable." But DOJ has not taken this view of federal court review of its consent decrees. After a consent decree was signed by the obstetricians of Cincinnati three years ago, there were several requests made of Judges Sandra S. Beckwith and Timothy S. Hogan to review the shotgun consent decree. In the Response to Public Comments by U.S. Attorney Gregory Lockhart concerning these requests, he stated that the Tunney Act (APPA) "does not permit the Court to review the efficacy or 'correctness' of the United States' enforcement policy or its determination to pursue – or not pursue – a particular claim in the first instance... the district court should not second-guess the prosecutorial decisions of the Antitrust Division..." He goes on to say that "the court is only authorized to review the decree itself." His statement contradicts the intent of the amended Tunney Act as noted by Senator DeWine and Chairman Sensenbrenner.

As a physician dedicated to providing the best care possible for my patients, and as a member of a labor union dedicated to the welfare of its members and all consumers, I am pleased

that the negative effect of antitrust enforcement policy on patient care is being examined by this Committee. A rebalancing of the contractual power between physicians and insurers needs to take place in order to guarantee patient access to quality medical care. ***Antitrust legislative reforms*** must include a reconsideration of the right of physicians to collectively negotiate with payers. ***Antitrust regulatory reforms*** must include an update of the *1996 Statements of Antitrust Enforcement Policy in Health Care* consistent with current market realities, and the collective negotiation rights necessary for physicians to develop and participate in quality initiatives such as Accountable Care Organizations. ***Antitrust enforcement reforms*** must start and end with an evenhanded application of the rules of competition by DOJ and the FTC consistent with the intent of the Sherman Act. That includes independent review of the last 35 consent decrees for fairness.

I want to thank Chairman Conyers, Chairman Johnson and members of the Subcommittee for holding this hearing. I am pleased to answer any questions you may have.

Reference Notes:

1. USA v. Federation of Physicians and Dentists, et. al. in Delaware (Case No. 98-475)
2. USA v. Federation of Physicians and Dentists, et. al. in Cincinnati (Case No. 1:05-cv-431)
3. USA and Idaho v. Idaho Orthopaedic Society, Idaho Sports Medicine Institute, Doerr, Hessing, Kloss, Lamey and Watkins (Case No. 10-268-S.EJL)
4. Peter J. Mandell, M.D. and AAOS, December 1, 2010, Statement on DOJ/FTC Enforcement of Antitrust Laws against Physicians to House Judiciary Subcommittee
5. Michael P. Connair, M.D. and AFSCME, July 29, 1998, House Judiciary Testimony in support of The Quality Health-Care Coalition Act of 1998
6. David Balto, "An Open Letter to the Next Federal Trade Commission Chairman," *GPC: The Online Magazine for Global Competition*, January 2009
7. Jay L. Himes, Chief, Antitrust Bureau, Office of the New York Attorney General, remarks to COMPTEL PLUS, Spring Convention and Expo, Las Vegas, NV, February 28, 2007.

Mr. JOHNSON. Thank you, Dr. Connair. We have got a series of votes, six of them, which we will go to after we hear from Attorney Balto. Please proceed, sir.

TESTIMONY OF DAVID BALTO, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS

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

You know, I want to compliment the Committee and its staff for all the work you have done. Justice Brandeis said that sunlight is the best disinfectant. And if he was here today, he would really applaud you for all the work the Committee has done in bringing attention to important competitive issues.

I am the former FTC Policy Director, and I usually represent consumer groups. And I asked myself the question, who represents the consumer? I think that is what this whole debate comes down to, who represents the consumer? Over the past decade, the FTC and the Department of Justice has said, in health care the insurance company represents the consumer; and they are wrong.

What has been the result of that misplaced set of priorities? 31 or 35 cases against doctors. Zero, zero cases against health insurers' anti-competitive conduct. Zero cases against deceptive and fraudulent conduct by the agencies. Massive consolidation leading to highly concentrated markets. I am a little worried. I don't know about you folks. You just went through a year-long, exhaustive debate on health care reform, and the representatives of the government couldn't tell you that the markets were overly concentrated. That is something to worry about.

What is the result of the misplaced priorities? 35 cases against doctors. I did look at all those cases. I examined them. Relatively few say that there was some harm. And the harm was insurance companies couldn't get the rates they wanted. Nothing about consumers in those complaints. Of those 35 cases, in only one case was the insurance company upset enough to file a private antitrust suit. Give me the money back. Nope. They have the FTC to do that. And they don't care about—there is no money to get because there is no harm. Did consumers file suits in those 35 cases? Zero. Not a one because consumers weren't harmed.

At the same time, what happens when doctors try to get together? Well, you have these 1996 guidelines which I helped author; and if you think those guidelines are up to date, if you think the health care world is the same as it was in 1996, you should bet on the Minnesota Gophers beating the Wolverines in football. The standards applied are so egregious it is impossible for doctors to get advice in a timely fashion.

Member Goodlatte asked us how long these letters take. I am surprised they didn't have the answer. The answer is on page 9 of my testimony. I went back and looked at the last six letters. I talked to the lawyers and doctors who had submitted letters to the FTC. The time period is between 245 to 645 days. The cost, over $100,000 in each case. The letters, exhaustive. When you go outside of health care and you want the advice from the government, it takes something like 2 to 3 months. Now the agency committed to a 90- to a 120-day period to get these letters done. This is clearly out of whack and needs to be reformed.

What is the result of this? Skyrocketing insurance premiums, record numbers of uninsured, diminishing reimbursement for these doctors, these dedicated doctors who are dedicated to serving the public, who are often forced into assembly line care.

Who suffers? Ultimately the patients suffer. What is the solution? First, we need vastly stronger health insurance enforcement and on both sides, looking both at consumers and on physicians.

There is a really important decision by the Third Circuit Court of Appeals on page 3 of my testimony that came out just this Tuesday. A large insurance company tried to exploit a hospital; and it said, We are not to blame in an antitrust sense. We are getting lower premiums. And the court said, You are wrong. Maybe you are giving them lower premiums, maybe you are not; but the way you are getting lower premiums is by giving consumers worse health care. You have to look at the total equation, look at the impact on patient quality, look at the impact on these doctors.

Second, the FTC should only bring cases against doctors and other providers if there is clear evidence of competitive harm. These 31 cases that they brought under their per se rule of illegality just didn't make a hill of difference and took the limited government resources away from more important things, like prosecuting health insurance companies.

Third, there needs to be new guidelines, and they need to have clear safe harbors. I have suggested one for pharmacies.

Finally, in terms of mergers, both Member Gonzalez and Member Conyers posed about how highly concentrated the market is. What can you do about that? Well, there is something you can do; and the FTC did it for hospitals in this last decade. Go back, do a study of consummated mergers, and attack those consummated mergers that have harmed consumers. You can challenge a merger even if it has been consummated.

I applaud the Committee's focus on these efforts, and I will look forward to trying to assist the Committee in trying to lead to sensible antitrust enforcement in the health care area.

[The prepared statement of Mr. Balto follows:]

PREPARED STATEMENT OF DAVID BALTO

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
Healthcare Providers, Insurers and Patients

December 1, 2010

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Statement of David Balto, Senior Fellow
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December 1, 2010

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 healthcare 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 healthcare antitrust enforcement needs to be revised in order for enforcement to fully support the objectives of healthcare reform. This nation's year-long debate on healthcare reform illuminated many faults and weaknesses in our healthcare system, while highlighting the potential for meaningful reform to improve healthcare 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 healthcare system.

Today's hearing on antitrust enforcement in the healthcare industry could not be more vital. The nation is taking the first critical steps toward implementing reform and making sure healthcare markets are competitive is a critical concern. That is why at the Center for American Progress we held a program on healthcare 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 healthcare 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

[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.

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 healthcare, but is an important solution for improving quality and cost in the fee-for-service healthcare system. Much of the healthcare debate focused on the lack of coordination among healthcare providers and how this led to excessive costs and poor healthcare results. The purpose of the Accountable Care Organizations (ACOs) is to provide entities that can better coordinate care and be held accountable for overall healthcare results.[2]
- If there is a competitive problem in healthcare markets it is due to aggregations of market power, such as in health insurance, and not because of improper integration among healthcare providers.

Many of these findings directly undermine the underpinnings of the current antitrust paradigm in healthcare. That paradigm assumes that healthcare intermediaries, such as health insurers or Pharmacy Benefit Managers (PBMs), are an appropriate proxy for the consumer in healthcare markets. The paradigm assumes that consumers will be better off if health insurers can use their power to drive down reimbursement rates relentlessly. It suggests that it is necessary to harbor deep suspicion over integration by healthcare 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 healthcare debate clearly demonstrated that a lack of integration led to more costly and lower quality care. Second, autonomous providers are too weak to bargain with insurance companies leading to increasingly reduced reimbursement and assembly line 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 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. Healthcare providers are often the most effective advocates for patients when insurance companies cross the

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[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 (June 24, 2010), and Douglas A. Hastings, "Accountable Care Organization Regulation and Enforcement: Coordinated or Siloed?" Health Law Reporter (September 23, 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).

line and engage in abusive and deceptive conduct. Healthcare providers can use their negotiating power to prevent insurers from implementing "physician gag" clauses which prevent physicians from informing consumers about insurance options. Healthcare providers can use their power to challenge deceptive conduct that harms both consumers and providers. Take the Ingenix case as an example – where United Healthcare's subsidiary deflated usual and customary rates harming millions of consumers.[4] It was associations of doctors including the AMA that led the charge in exposing these practices, leading to a landmark remedy and over $350 million in damages to date.

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

This was recognized in a decision 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 healthcare where quality of care is a central concern.

It is time for our antitrust enforcers to recognize the lessons from healthcare reform and adapt the antitrust paradigm. As I discuss in more detail below, the history of the past decade is

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

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 healthcare enforcement actions were against efforts by physicians to collectively negotiate. Physician collaboration has been living as a suspect class and represents the only area where antitrust agencies apply the "per se" label and condemn endeavors without analysis of anticompetitive effects. (The "per se" rule is the legal guillotine of the antitrust laws. Under the per se rule, the government need not demonstrate the conduct has harmed competition or consumers.) The FTC brought 31 cases, all settled, probably because of the high cost of a government investigation. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did consumers file any antitrust suits seeking damages for the alleged illegal conduct. (There was only one case filed by an insurer and it lost.)[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 4 years of the Clinton Administration and only 5 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 healthcare 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.**
- **Healthcare 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 Healthcare 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**

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[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 Healthcare Association*, Case No. 2:07-cv-01292 (D. AZ. 2007). I was co-lead attorney for the class of nurses.

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 healthcare – 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% of the market and in nine states a single firm controls at least 75% of the market.[8] A 2009 AMA study found almost 99% 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.

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[7] The chronic competition and consumer protection problems are detailed in the testimony of David A. Balto 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," May 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."

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 of five personal bankruptcies. At the same time from 2000 to 2007, the 10 largest publicly-traded health insurauce companies increased their annual profits 428 percent, from $2.4 billion to $12.9 billion.**

II. Realigning Healthcare Enforcement Priorities

If one fact is clear from over a year of healthcare 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 healthcare 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 healthcare 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' 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 in to improve overall healthcare 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.**

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

- **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 affects. 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 Healthcare (Guidelines), last revised in 1996, over fourteen years ago. Obviously the healthcare 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 4 years under the Guidelines approximately 30 letters were issued and the timing commitments were usually met.

In the past ten 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 healthcare.

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 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. Senators Kohl, Leahy, Feinstein, Whitehouse and Specter recognized the need to revise the Healthcare Guidelines in a letter to AAG Varney and Chairman 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 Healthcare Guidelines. Conceivably, the agencies may impose very strict requirements, or may see physician cartels lurking behind these arrangements. As the

[11] Senators Kohl, Leahy, Feinstein, Whitehouse and Specter, Letter to Assistant Attorney General Varney and Chairman Leibowitz, November 3, 2009.

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 professional 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 fashiou.**

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 healthcare and control costs. Pharmacists can play a critical role in these efforts, since

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[12] Statement of the AMA for the ACO Workshop (Sept. 27, 2010).

[13] Remarks of FTC Chairman Jon Leibowitz as Prepared for Delivery. FTC/CMS Workshop on Accountable Care Organizations, October 5, 2010, available at http://www.ftc.gov/opp/workshops/aco/docs/leibowitz-remarks.pdf.

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 healthcare management. As a result of face-to-face service and personal relationships, pharmacists can help patients manage lifestyle choices, 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 Healthcare 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 3 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

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[14] Karen Ravn, "Clinical pharmacists can fill in healthcare 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, Augnst 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; *see 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 testimony of David A. Balto before the House Judiciary Committee Antitrust Task Force on the Impact of our Antitrust Laws on Community Pharmacies and Their Patients (October 18, 2007).

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 healthcare 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.

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[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.

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 healthcare 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 non-hospital provider groups possess market power seems less clear from the perspective of the enforcement agencies. I reviewed all past healthcare 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 healthcare 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.

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[20] 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% 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).

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 healthcare 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.

Mr. JOHNSON. Thank you, Mr. Balto. One of the issues being pro-consumer price savings versus doctors' abilities to eke out an honest and profitable occupation or profession is very important. And you have struck upon a couple of interesting points that I would love to follow up on today. However, with the six votes, it is going to take us some time to be able to return here, and then there are

other things on our agenda for this afternoon. So we will have to reschedule this hearing, and we will adjourn it today.

Thank you for coming.

And by the way, before I adjourn, without objection, Members will have 5 legislative days to submit any additional written questions which we will forward to the witnesses. You have not had any questions yet. So we will have you back. Thank you.

[Whereupon, at 12:11 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

RESPONSES TO QUESTIONS POSED DURING THE HEARING TO SHARIS A. POZEN, CHIEF OF STAFF AND COUNSEL TO THE ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Inserts of Information Requested by the House Judiciary Committee

For the December 1, 2010, Hearing on the "Antitrust Laws and Their Effects on Health Care Providers, Insurers and Patients"

Information for page 43:

In the last ten years, the Antitrust Division has brought three cases against physicians and other individual providers; no cases against hospitals; and four cases in the health insurance industry—the Division challenged three health insurance mergers (one led the parties to abandon the deal after the Division announced its intention to challenge) and brought one case challenging an insurer's use of anticompetitive most favored nation clauses.

Information for page 44:

The messenger model is an arrangement that allows contracting between providers and payors, while avoiding price fixing among competing providers. Statement 9 of the Antitrust Division and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care describes messenger model arrangements and discusses the variety of ways they can be organized and operated while steering clear of being used merely as a vehicle for price fixing or otherwise violating the antitrust laws. In addition, the agencies' report, "Improving Health Care: A Dose of Competition," (Health Care Report) Chapter 2, Section III, recounts commentators' and panelists' perspectives on messenger models from joint hearings the agencies held in 2003 on competition in health care markets. For example, some panelists found that the messenger model can simplify contracting and contract administration, thereby reducing physicians' and payors' transaction costs. *See* Health Care Report, at 16.

Information for page 45:

The Antitrust Division and the Federal Trade Commission maintain records on the number of mergers and acquisitions that have been reported to the agencies under the Hart-Scot-Rodino Antitrust Improvements Act of 1976, including the number within specific industries defined by the North American Industry Classification System (NAICS). There are a number of transactions that are not reportable because they, for example, do not meet the size thresholds under the Act.

According to the Division's statistics, under the NAICS code defining "direct health and medical insurance carriers," there have been 78 transactions reported to the antitrust agencies in the last ten years. Under NAICS codes that define industries only in health care, across all health care industries—including health insurance, ambulatory health care service, hospitals, medical laboratories, and other health industries—there have been 401 transactions reported to the antitrust agencies in the last ten years.

Information for page 46:

Under the Horizontal Merger Guidelines issued by the Antitrust Division and the Federal Trade Commission, markets having a Herfindahl-Hirschman Index (HHI) above 2,500 are classified as "highly concentrated." These thresholds do not provide a rigid screen to separate competitively benign mergers from anticompetitive ones, but rather, they provide one way to identify some mergers unlikely to raise competitive concerns and some others for which it is particularly important to examine whether other competitive factors confirm, reinforce, or counteract the potentially harmful effects of increased concentration. According to the Guidelines, the "higher the post-merger HHI and the increase in the HHI, the greater are the Agencies' potential competitive concerns and the greater is the likelihood that the Agencies will request additional information to conduct their analysis." U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (2010), § 5.3.

The American Medical Association (AMA) has published estimates of HHIs for health insurers in U. S. Metropolitan Statistical Areas (MSAs). Market analysis under antitrust law is fact-specific and not defined generically by MSAs. Thus, the boundaries of any particular antitrust market may differ from MSA boundaries. The AMA's estimates of MSA shares of health insurance competitors (HMOs and PPOs) show about 70% of MSAs have HHIs above 2,500.

RESPONSES TO POST-HEARING QUESTIONS FROM RICHARD FEINSTEIN, DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION, WASHINGTON, DC

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Office of the Director

February 4, 2011

The Honorable Henry "Hank" C. Johnson, Jr.
Chairman
Subcommittee on Courts and Competition Policy
Committee on the Judiciary
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Johnson:

Attached are my responses for the record from the December 1, 2010 hearing on "Antitrust Laws and Their Effects of Healthcare Providers, Insurers and Patients."

Sincerely,

Richard A. Feinstein

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

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1. Representative Bob Goodlatte, Member of the Subcommittee on Courts and Competition Policy, asked Mr. Richard Feinstein, Director, Bureau of Competition, Federal Trade Commission, to provide the average amount of time it takes for Federal Trade Commission to provide a staff advisory opinion on health-care issues.

You have requested that the Federal Trade Commission provide you with information regarding the time it takes to receive an FTC staff advisory opinion regarding health-care issues. By way of background, each year a number of different types of health-care provider organizations request advice from the FTC in the form of either an advisory opinion or informal guidance prior to engaging in a particular course of action. In fact, many more seek informal guidance than ultimately request an advisory opinion. Indeed, it is important to note that an advisory opinion from the Commission or its staff is not a prerequisite to doing business, and the vast majority of health-care providers implement their programs on the basis of private opinions of counsel or informal guidance from FTC staff, or based on previously issued advisory opinion without going through the process of seeking a written advisory opinion.

Our best estimate is that issuance of such opinions generally takes, on average, between four and six months after all the necessary information has been submitted to staff by the parties requesting the advisory opinions. However, as described in more detail below, it is difficult to provide precise information regarding the length of time it takes to issue a written advisory opinion, because different types of advisory opinions require different amounts of time. The length of time depends on a number of factors that vary markedly from request to request, including: (1) the subject matter of the request, and the number and complexity of the legal and factual issues it raises; (2) the completeness, clarity, and specificity of the information submitted in the request; (3) the time it takes the requester to provide additional information necessary for staff to evaluate the request; (4) the clarity of the law regarding the subject of the request and the issues it raises; and (5) the number of advisory opinion requests that are under consideration at any given time, and, relatedly, the agency resources available to analyze the requests and draft the responses. Most of these factors are beyond the control of FTC staff, and because there are so many varying factors it is difficult to provide an accurate or meaningful average.

Some advisory opinions raise simpler issues, and we can issue them more quickly. For example, more than half of the FTC staff advisory letters issued by the Health Care Division since 2000 have involved questions about the applicability of Nonprofit Institutions Act exemption to the Robinson-Patman Act. Typically, these requests raise only a single issue, the applicable legal standard is relatively clear, there is well-developed case law, and the requests involve generally similar factual circumstances. Advisory opinions in a variety of other areas -- such as information gathering and information-sharing arrangements among health-care providers, or provider network arrangements that did not involve competitor pricing agreements -- have likewise been issued relatively quickly from health-care providers.

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The one area where it has taken Commission staff considerably more time to issue advisory opinions is for physician and other health-care provider network arrangements that involve price agreements among competing providers and the collective negotiation of contracts with health-care payers. These requests involve conduct that in other contexts would constitute *per se* illegal price fixing, and the staff must scrutinize them very carefully to ensure that the proposed conduct would not increase health care costs to consumers. In most cases, the requesters claim that the proposed pricing arrangements are justified under the antitrust laws because they are reasonably necessary to facilitate the achievement of efficiencies – specifically, through "clinical integration" among the providers. These advisory opinions typically have taken longer to issue for a variety of reasons, including the following:

1. The initial request for an advisory opinion is often incomplete, and it takes time for staff to carefully review the initial request and identify the additional information needed to properly evaluate it. It also generally takes requesters a substantial amount of time to provide sufficient additional information for staff to be able to understand the operation of the proposed program and do the necessary factual and legal analyses. The time that requesters have taken to respond to requests for additional information has varied markedly, often taking many months. And, in some cases, multiple follow-ups have been required.

2. These are very complex factual and legal assessments. There is little clear legal precedent directly applicable to such arrangements, and because joint pricing by competitors can create significant harm to competition and to consumers, the staff must take care to correctly apply existing joint venture law to the specific, and often unique, factual circumstances of the proposed program. In considering the level of caution warranted when evaluating such requests, it is instructive to bear in mind that the Commission and the Department of Justice have brought many antitrust enforcement actions against provider network joint ventures that appear similar to those being reviewed. These are arrangements that require the staff to make difficult judgments regarding the participants' degree of efficiency-enhancing integration, the potential and likelihood of achieving substantial integrative efficiency benefits, the need for, or "ancillarity" of, the arrangement's competitive restraints to the achievement of its efficiency benefits, and an assessment of whether the proposed conduct will allow the participants to increase or exercise market power.

3. These opinions are widely viewed as a barometer of Commission enforcement policy. Although the primary purpose of an advisory opinion is to respond to the specific request at issue, these opinions also are closely read by other health-care providers (and their counsel), who may be contemplating similar arrangements. Consequently, staff must ensure that its analysis is not only sufficiently clear and detailed to serve the needs of this wider audience, but also consistent with broader competition policy goals. Accordingly, the advisory opinions that have been issued in this area have been considerably longer

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and more detailed than those issued regarding other subject areas. For example, the most recent such letter was 37 pages.

In order to help health-care providers understand and engage in the Commission's advisory opinion process, and to facilitate the review and issuance of advisory opinions, FTC staff have developed a detailed guide entitled "Guidance from Staff of the Bureau of Competition's Health Care Division on Requesting and Obtaining an Advisory Opinion." This document fully explains the process and provides information to help expedite it. This guide can be found at http://www.ftc.gov/bc/healthcare/industryguide/adv-opinionguidance.pdf.

Although the complexity of these requests and factors beyond the control of staff (such as the receipt of complete information) in large part dictate the timing of advisory opinions, we are reviewing the process to see if advisory opinions on health-care provider networks can be issued more quickly without sacrificing the careful analysis needed to ensure the arrangements do not violate antitrust law.

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