Testimony

for

House Judiciary Committee

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

by
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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*.

[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.