Prepared Statement of
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Subcommittee on Regulatory Reform, Commercial and Antitrust Law

On

"The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition"

September 10, 2015

Chairman Goodlatte, Subcommittee Chairman Marino, Committee Ranking Member Conyers, Subcommittee Ranking Member Johnson, and Members of the Subcommittee, I much appreciate the opportunity to testify on the important issue of health care competition policy and the Affordable Care Act. By way of introduction, I am the Chester A. Myers Professor of Law and Director of the Center for Health Law Studies at Saint Louis University School of Law. I have devoted most of my 28-year academic career to studying issues related to competition and regulation in the health care sector, writing numerous articles on the subject and co-authoring the leading casebook in health law. Before that I served as Assistant Chief in the Antitrust Division of the United States Department of Justice, litigating and supervising cases involving health care. My professional affiliations include membership in the American Health Lawyers Associations and I serve on the Advisory Board of the American Antitrust Institute.

Let me summarize the key points of my analysis of the effects of the Affordable Care Act on Competition and the problems presented by provider and insurance sector mergers:

- The Affordable Care Act depends on and promotes competition in provider and payor markets.

- Excessive concentration in hospital, physician, insurance, pharmaceutical and medical device markets undermines the pro-competitive policies of the Affordable Care Act.

- It would be erroneous to claim that the Affordable Care Act is somehow responsible for anticompetitive consolidation among providers and payers when in fact such mergers and joint ventures are efforts to *avoid or frustrate* the procompetitive aspects of the Act.

- The recently announced mergers in the insurance industry threaten competition in a variety of product markets around the country and should be closely scrutinized by the Department of Justice, with careful attention to the effectiveness of any proposed spin off remedies.

- State and Federal legislatures could promote competitive conditions by removing regulatory barriers to entry and laws that limit applicability of antitrust law; adopting procompetitive laws increasing price transparency and entry opportunities; and eliminating payment incentives that artificially encourage consolidation.

Competition Policy and the Affordable Care Act

I'd like to begin by repeating an important proposition that I advanced in my testimony before this Committee two years ago and that is sometimes lost in the rhetoric about health

reform.[1] The Affordable Care Act both *depends on* and *promotes* competition in provider and insurance markets. A key point is that the new law does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public. Moreover the Act puts in place a number of regulations that provide greater transparency and choice and reverse the seriously flawed incentives that plagued health care markets prior to 2010. Thus the ACA vastly improves conditions necessary for competition to take hold and flourish.

Why do we need government intervention to make health care markets perform more efficiently? Let's remember what the putative "market" for health care looked like before reform: A dysfunctional market for individuals and small groups; a *nonsystem* of service delivery in which hospitals, physicians, and other providers operated in silos; and reimbursement arrangements that rewarded volume, not quality or outcomes. The underlying causes were a witches' broth of history, provider dominance, ill-conceived government payment and regulatory policies, and perhaps most importantly, market imperfections that are endemic to the delivery of services, insurance, and third party payment. Justification for regulation as an important vehicle for promoting competition can be found in virtually every economic analysis of health care. Markets for providing and financing care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly and selection in insurance markets that greatly distort markets. Add to that governmental failures— payment systems that reward intensity and volume, but not accountability for resources or outcomes; restrictions on referrals that impede efficient cooperation among providers; and entry impediments in the form of licensure and certificate of need laws, to name a few. Finally, toss in a strain of professional norms that are highly resistant to marketplace incentives—and you have the root causes of our broken system.[2]

What has the ACA done to improve market competition? First, by establishing health insurance exchanges to facilitate comparative shopping at the consumer level, the law put in place efficient markets for offering and purchasing individual and small group health insurance around the country. Further, the Act's requirements that insurance products be comparable, understandable, and assure basic minimums of coverage are textbook measures that help promote competition in the insurance market. The result: well-functioning exchange markets that have enabled over 10 million people to shop for and find affordable insurance that was not available before health reform.[3]

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[1] Greaney, Thomas L. Prepared Statement to House, Committee on the Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law. *"The Patient Protection and Affordable Care Act and the Consequent Impact on Competition in Healthcare"*, Hearing, September 19, 2013 (Serial 113-.51). Available at: http://judiciary.house.gov/_files/hearings/113th/09192013_2/Greaney%20Testimony.pdf; Accessed: 9/7/15.

[2] For a more detailed discussion of my views on the ACA's capacity to improve competition *See* Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811 (2011).

[3] Press Release, U.S. Dep't of Health and Human Services, *March Effectuated Enrollment Consistent with Department's 2015 Goal* (Jun. 2, 2015), *available at* http://goo.gl/4tPGxO.

Moreover, exchanges have induced insurers to compete in many but not all markets: on average, six different insurers competed on each exchange this year, an increase of one insurer per exchange from 2014.[4] The increased offerings on the exchanges benefitted consumers as premiums increased by marginal amounts from 2014 to 2015.[5] The following statistics about competition on the exchanges are noteworthy:

- 86% of qualified health plan eligible individuals had access to at least three issuers in 2015 (up from 70% in 2014 and an average gain of one issuer/county)
- Average premium growth rate in the second lowest silver plan was 2%
- Growth in silver plans was 8.4% lower where there was a net gain in issuers[6]

Further, doomsday predictions about the exchanges and insurance reforms have proven unfounded. For example, the claim that risk selection would destroy the exchanges was erroneous as risk adjustment and other regulations have tempered the insurance industry's long-standing practice of chasing down only good risks.[7] Likewise doubts that the exchange would facilitate shopping and reduce uninsurance were quite wrong. Together with Medicaid expansion in those states that have chosen to do so, the number of uninsured citizens has dropped by over 52 percent since the enactment of the ACA.[8] Further, the ACA reforms did not disrupt the private commercial market: the employer-sponsored insurance market is stable, as employer offerings of insurance, employee take-up and coverage have remained unchanged.[9]

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[4] *Number of Issuers Participating in the Individual Health Insurance Marketplaces*, KAISER FAMILY FOUNDATION (2015)(while the average number of insurers per exchange was six, Alaska, Delaware, Hawaii, West Virginia, and Wyoming all had two or fewer insurers competing on their exchange) http://kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/.

[5] *See* Steven Sheingold, Nguyen Nguyen, & Andre Chappel, *Competition and Choice in Health Insurance Marketplaces, 2014-2015: Impact on Premiums*, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION DEP'T. OF HEALTH AND HUMAN SERVS. (Jul. 27, 2015) http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums.

[6] *Id.*

[7] Michael J. McCue & Mark Hall, *Comparing Individual Health Coverage on and Off the Affordable Care Act's Insurance Exchanges*, THE COMMONWEALTH FUND (Aug. 18, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/comparing-coverage-on-off-aca-exchanges.

[8] Sharon K. Long, *et al*., *Taking Stock: Gains in Health Insurance Coverage Under the ACA as of March 2015*, URBAN INSTITUTE (Apr. 16, 2015) (in states that have expanded Medicaid, uninsurance has fallen by 52.5 percent as of March 2015), http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html.

[9] Fredric Blavin, *et al*., *Employer-Sponsored Insurance Continues to Remain Stable under the ACA*: *Findings from 2013 through March 2015*, URBAN INSTITUTE (Jun. 3, 2015), http://hrms.urban.org/briefs/Employer-Sponsored-Insurance-Continues-to-Remain-Stable-under-the-ACA.html.

Second, the ACA has created strong incentives for providers and payers to develop innovative organizational structures that can respond to payment mechanisms that rely on competition to drive cost containment and quality improvement. Congress recognized that it was essential to stimulate formation of organizations that could receive and distribute reimbursement and be responsible for the quality of care under the new payment arrangements developing both in Medicare and in the private sector. The Centers for Medicare and Medicaid Services (CMS) has exercised authorities given by the ACA to speed the transition to more rational payment, announcing recently its target of moving 85 percent of Medicare fee-for-service payments into value based purchasing categories by 2016.[10] Today we see the fruits of the ACA's payment initiatives in the private sector, as these incentives have unleashed a torrent of innovation and change in the coordination and delivery of care. Providers around the country are integrating their delivery and payers are increasingly adopting payment arrangements that reward quality and create incentives for providers to control costs.

Finally, the ACA deals with a very significant "public goods" market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. Here the ACA promotes a concept that might not seem so radical but for its absence in practice: reliance on "evidence based medicine." The law does so by subsidizing research and creating new entities to support such research and to disseminate information about outcome and medically-effective treatments. Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies and add incentives to improve quality and reward value by paying for performance and developing validated process and outcome metrics.

The Effects of Provider and Payer Concentration on Competition

So, is everything copacetic? Unfortunately, it is not. Many observers, including myself, have pointed to the extensive concentration that pervades health care markets and constitutes a serious impediment to effective competition. It is important however to put this phenomenon into context—both as to how it came about and what can be done about it.

A large body of literature documents the existence, scope and effects of market concentration. One well-regarded compilation of the numerous studies of this issue spells out the link between hospital market concentration and escalating costs of health insurance: hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.[11] Another important study, undertaken by the Massachusetts Attorney General, documents the effects of "provider leverage" on health care costs and insurance premiums, notably finding prices for health services are

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[10] CMS, 2015 Fact Sheet, *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume,* (Jan. 26, 2015) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html.

[11] William B. Vogt & Robert Town, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (Feb. 2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

uncorrelated with quality, complexity, proportion of government patients, or academic status but instead are positively correlated with provider market power.[12] A leading economist summarized the impetus to merge with rivals in the face of pressure from payers to compete:

> I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.[13]

In recent years, hospitals have begun to acquire physician practices in large numbers. While vertical integration through employment can help reduce costs and improve the quality of care, concerns arise where a hospital acquires such a significant share of physicians in a relevant market so as to enhance its bargaining power with payers or foreclose rival hospitals from competing effectively.[14]

Evidence of the effect of market concentration in commercial insurance markets, although not as robust as for hospital markets, also indicates that insurance mergers have led to higher premiums for consumers. [15] Retrospective studies of health insurance mergers have found significant price increases following consolidation.[16] Payer concentration has also translated into

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[12] MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B) (Mar. 10, 2010), *available at:* http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf (compare with the 2011 and 2013 updates), *available at* http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf and http://www.mass.gov/anf/docs/hpc/ag-presentation.pdf, respectively.

[13] David Dranove, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 122 (2000).

[14] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending*," 33(5) HEALTH AFFAIRS 756 (May 2014) (One of the few studies examining the relationship between hospital-physician consolidation and performance finds hospital ownership of physician practices, as contrasted with looser forms of contractual integration, associated with higher hospital prices and spending); Moreover, analysis of health system organizations suggests that historically economic integration has failed to generate clinical integration that results in either cost savings or improved efficiency, Jeff Goldsmith, Lawton R. Burns, Aditi Sen & Trevor Goldsmith, INTEGRATED DELIVERY NETWORKS: IN SEARCH OF BENEFITS AND MARKET EFFECTS (National Academy of Social Insurance) (Feb. 2015)(summarizing literature and analyzing performance of 15 of the largest integrated delivery systems).

[15] Leemore Dafny, *Are Health Insurances Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

[16] Leemore Dafny *et al*., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,* 102 AM. ECON. REV. 1161 (2012)(concluding that the average increase in local market concentration resulting from the merger had the effect of raising premiums by approximately 7 percent over an eight year period); Jose Guardado et al. *The Price Effects of a Large Merger of Health Insurers: A Case Study of United-Sierra*, 1(3) HEALTH MANAGEMENT, POL'Y & INNOVATION 16 (2013)(finding premium increases of 13.7 percent for fully-insured small group plans in Nevada markets where the merger increased concentration significantly),

higher premiums on the exchanges: a study of health insurance premiums on the federally facilitated marketplaces found that adding one additional insurer would lower premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent.[17]

Thus in many markets provider and payer concentration potentially can undermine the benefits that competition offers. However, before one leaps to the conclusion that the Affordable Care Act is responsible for this state of affairs, a little history is in order. Notably, the largest number of seriously concentrative hospital mergers was undertaken *after* the defeat of the Clinton Health Reform proposal and during a time when managed care was at its zenith. While academics disagree on what caused the sharp increase in mergers, recent studies suggest that hospitals' anticipation of increased cost pressures from managed care led them to consolidate. Moreover, one thing is clear: a series of unsuccessful antitrust challenges to hospital mergers in federal court gave a green light to consolidation. And, as the government antitrust agencies themselves admit, these decisions caused federal and state enforcers to back away from challenging hospital mergers for almost seven years.[18] Adding to this tale of misfortune is the widely-held opinion that the courts got it wrong: the majority of judicial decisions allowing hospital mergers found unrealistically large geographic markets that did not conform to sound economic analysis.[19]

To be sure, the ACA gives providers incentives to link together through mergers and joint ventures in order to receive bundled payments and profit from shared savings that flow from providing care more efficiently. However, as antitrust enforcers have pointed out,[20] the law depends on market competition; hence mergers creating or entrenching market power are

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http://www.hmpi.org/pdf/HMPI%20-%20Guardado,%20Emmons,%20Kane,%20Price%20Effects%20of%20a%20Larger%20Merger%20of%20Health%20Insurers.pdf.

[17] Leemore Dafny *et al*., *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces* KELLOGG INSIGHT (Jul. 7, 2014), http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums.

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

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

[20] Former acting Assistant Attorney General Sharis A. Pozen, DOJ Antitrust Division, Remarks at World Annual Leadership Summit on Mergers and Acquisitions in Health Care: Competition and Health Care: A Prescription for High-Quality, Affordable Care (Mar. 19, 2012)("The success of health care reform will depend as much upon healthy competitive markets as it will upon regulatory change. If health care reform is to produce more efficient systems, bring health care costs under control and provide higher-quality health care delivery, then we must vigorously combat anti-competitive mergers and conduct that harm consumers with responsible antitrust enforcement.")

anathema to the underlying purposes of system reform. Likewise, courts have not accepted what I call the "ACA Made Me Do It Defense"--the claim that anticompetitive mergers could be justified on the grounds that health reform creates incentives for consolidation. [21] As the author of the leading treatise on antitrust law and the health care industry has written,

> Nothing in the ACA…suggests that firms integrate or coordinate in ways that generate market power, whether through total or partial integration…In enacting the ACA, Congress envisioned programs that would stem or decrease the cost of health care and increase its quality. Difficult to see is how permitting provider mergers or other forms of integration *that result in market power* furthers the congressional goal of lower health-care costs. [22]

Indeed, it should be clear that anticompetitive mergers, joint ventures, and cartels are at bottom efforts to *avoid* the very pro-competitive policies the ACA puts in place.

The good news is that in recent years the Federal Trade Commission, the Antitrust Division, and a number of State Attorneys General have stepped up antitrust enforcement and the FTC has won a series of important victories in merger challenges in federal court.[23] These cases should send a clear signal that hospital and physician mergers will be closely scrutinized. Moreover they establish important precedents that most service delivery markets are highly localized, entry is not easy, and mergers that increase providers' bargaining leverage with payers is a core competitive concern. However, the problem of dealing with *extant* monopolies and oligopolies is significant and one that antitrust law has little power to rectify. In this connection, I will suggest at the end of my testimony a few steps in which legislatures and regulators can take to temper the power of dominant providers and payers.

Mergers among Health Insurers

Although not the primary focus of today's hearing, the recently announced agreements of Aetna Inc. to acquire Humana Inc. and of Anthem Inc. to acquire Cigna Corporation, have focused attention on the problems that increasing concentration on the payer side may cause for

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[21] *See FTC v. St. Luke's* (holding the Clayton Act does not authorize the court to "conduct an experiment" to see if predicted consumer harm actually occurs.) Other cases have dealt summarily with claims that the ACA compels anticompetitive mergers. *FTC v. ProMedica Health Sys., Inc*., 2011 WL 1219281 (N.D. Ohio 2011) aff'd 749 F.3d 559 (6th Cir. 2014); FTC v. OSF Healthcare Sys., 852 F.Supp. 1069 (N.D. Ill. 2012).

[22] John J. Miles, *Anatomy of a Provider-Merger Antitrust Challenge*, 6 OBER|KALER Health L. Alert Newsletter (2015) http://www.ober.com/publications/2908-anatomy-provider-merger-antitrust-challenge-part-5#41.

[23] *See e.g., St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775, 788 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 571 (6th Cir. 2014); FTC v. OSF Healthcare Sys., 852 F.Supp. 1069 (N.D. Ill. 2012). *See also*, Opinion of the Commission, *In the Matter of* Evanston Northwestern Healthcare Corp., F.T.C. No. 9315; *In the Matter of* Renown Health, F.T.C. C-4366 (Dec. 4, 2012) (consent decree, Aug. 6, 2007).

consumers. Unravelling the extent of current competition between the merging parties will require a careful investigation of overlapping business in a number of distinct insurance product markets including those serving: individuals and small groups; Medicare Advantage beneficiaries; large fully insured employers; self-insured employers; and perhaps others. Moreover because competition in most of these markets is local--roughly equating to that of hospital service markets--the Antitrust Division of the Department of Justice faces a daunting task of fact gathering. Below I offer a few observations about several legal and policy issues embedded in this inquiry.

Medicare Advantage as a Distinct Product Market

With over 30 percent of Medicare beneficiaries choosing to receive services from private Medicare Advantage plans, competition in these local markets is vitally important. At present, Medicare Advantage markets are highly concentrated, with some 97 percent of markets exceeding federal Merger Guidelines standards for high concentration.[24] This has important implications not only for the cost-containment objectives of the Medicare Advantage program but for proposals to convert Medicare to a premium support program.[25] For antitrust analysis, Medicare Advantage plans likely constitute a distinct product market because of the way private plans compete for inclusion in local markets and the special services and benefits they offer. As the Department of Justice has recognized in challenges to several health insurance mergers,[26] private insurance companies compete to offer the most attractive Medicare Advantage benefits to enrollees in a region typically offering substantially richer benefits at lower costs to enrollees than traditional Medicare, such as lower co-payments, caps on total yearly out-of-pocket costs, prescription drug coverage, vision coverage, health club memberships, and other benefits that traditional Medicare does not cover. While it is true that traditional Medicare constrains the pricing power that providers can exert against Medicare Advantage plans,[27] the two are distinct product offerings under well-established antitrust market definition principles.

Health Insurance Exchanges and Potential Competition

As discussed above, Health Insurance Exchanges play a vital role in spurring competition among insurers in the individual and small group markets. The hope that new business would attract increasing competition among insurers in these markets has only been partially realized. We do know however that where competitive entry has occurred, consumers have reaped the

[24] Brian Biles, Giselle Casillas, Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does it Really Exist?* THE COMMONWEALTH FUND (Aug. 25, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.

[25] *See Id.* (like Medicare Advantage, premium support proposals would rely on bids submitted by a small number of insurers in each local market).

[26] *See* Complaint, *United States v. UnitedHealth Group Inc.* No. 08-cv-322 (D.D.C. 2008), http://www.justice.gov/atr/case-document/response-plaintiff-united-states-amas-and-seius-motion-leave-appear-amici-curiae.

[27] *See* Robert A. Berenson *et al*., *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFF. 1289 (Aug. 2015).

benefit of lower premiums.[28] One empirical study analyzing 34 federally facilitated marketplaces found that adding one additional insurer lowered premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent.[29]

An important issue therefore is whether the proposed mergers will lessen *potential competition* that was expected under the ACA (the potential entry by large insurers into each others' markets, incidentally, was the argument advanced as to why a "public option" plan was unnecessary). At present all four of the merging companies compete on the exchanges and they overlap in a number of states.[30] Notably, prior to the announced mergers, these insurers appear to have been considering further expanding their footprint on the exchanges by entering a number of new states.[31] Thus, reducing the array of formidable potential entrants into exchange markets from the "Big 5" to the "Remaining 3" will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor's market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.

One further complication affecting potential competition in all product markets: Anthem is one of 36 independent companies that operates under the "Blue" trademarks of the Blue Cross and Blue Shield Association. A requirement of operating under the marks is that each licensee compete as a Blue plan only in a designated "service area" and also abide by the "two-thirds rule," which mandates that two-thirds of annual revenue from each Blue mark holder be attributable to service offered under the Blue marks. The anticompetitive aspects of this agreement, which are the subject of an antitrust class action lawsuit,[32] have clear implications regarding actual and potential competition in the insurance sector should the Anthem/Cigna merger be permitted to go forward in that the restrictions appear to prohibit Anthem/Cigna from expanding its non-Blue business and may require Cigna to be pulled out of certain markets or to stop competing for new business.

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[28] For example, in 2014, after PreferredOne-- the largest insurer on the Minnesota exchange and which had offered the lowest rates-- pulled out of the exchange for 2015, the four remaining insurers sought an average 35 percent rate increase for 2016. Louise Norris, *Minnesota Health Insurance Exchange / marketplace*, HEALTHINSURANCE.ORG (July 28, 2015), http://goo.gl/YuUKcG.

[29] Leemore Dafny, Jonathan Gruber, & Christopher Ody, *More Insurers, Lower Premiums: Evidence from Initial Pricing on the Health Exchanges*, 1 AM. J. OF HEALTH ECON. 53, 60 (2015).

[30] *See Health Insurance Exchanges or Marketplaces: State Profiles and Actions*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://goo.gl/JMYAgN (last visited Sept. 8, 2015).

[31] *See* Bruce Japsen, *With Insurer ACA Expansions In 2015, More Obamacare Choices, Competition*, FORBES (Aug. 3, 2014).

[32] *See* Letter from Joe R. Whatley, Jr., Edith M. Kallas and Henry C. Quillen to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (Aug. 13, 2015)(letter from counsel for plaintiffs in *In re Blue Cross Blue Shield Antitrust Litigation*, MDL No. 2406 No. 13-cv-2000 (N.D. Ala.) regarding the Anthem-Cigna merger).

Countervailing Power: The Sumo Wrestler Theory Fallacy

A defense likely to be advanced by the insurance companies posits that the mergers will enable payors to counter the market power of dominant "must-have" hospitals and specialty physician practices.[33] This argument, which I have called the "Sumo Wrestler theory," holds that only a large payor can effectively bargain down the prices demanded by large providers. Payors, it is assumed, will then pass along the savings to their customers. To be sure, there is substantial evidence that a large share of health care cost increases is caused by dominant providers charging high prices. However, there are a number of reasons to be skeptical of the idea that consolidated insurers will bargain down prices with providers. First, there is no compelling economic evidence that "bilateral" monopoly produces better results for consumers; and even if a dominant payor succeeds in bargaining successfully with providers it has little incentive to pass along the savings to its policyholders. Accordingly, antitrust law has been skeptical about applying a "power buyer" defense to mergers.[34] Moreover, whether accomplished by coercion or sharing the fruits of monopoly rents, there have been many instances in which insurers and hospitals have conspired to disadvantage their rivals.[35] As an example, the Antitrust Division challenged Blue Cross Blue Shield of Michigan, the dominant insurer in the state, use of most-favored nation ("MFN") clauses, which guaranteed Blue Cross the most favorable insurance rates while forcing providers to raise rates on all other insurers in the state.[36] In sum, experience suggests that a showdown between the Sumo Wrestlers may well result in a handshake[37] rather than an honest wrestling match.

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[33] *See* Victor R. Fuchs & Peter V. Lee, *A Healthy Side of Insurer Mega-Mergers*, WALL ST. J. (Aug. 26, 2015).

[34] *See* Phillip Areeda & Herbert Hovenkamp, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 943b (power buyer factor rarely if ever dispositive in merger cases and concluding " it would be inappropriate to give formal recognition to buyer concentration and related factors in the ordinary run of merger cases").

[35] *See e.g.*, *West Penn Allegheny Health System Inc. v. UPMC*, 627 F.3d 85 (3d Cir. 2010); *Texas v. Memorial Hermann Healthcare Sys.*, No. 2009-04609 (Tex. Dist. Ct. filed Jan. 26, 2009) (settling antitrust claims that largest hospital system in Houston discouraged commercial insurers from contracting with rival hospitals by threats of termination or demands for large increases in reimbursement); *Heartland Surgical Specialty Hospital v. Midwest Division, Inc*., 527 F.Supp.2d 1257, (D. Kan. 2007) (denying summary judgment in case involving alleged conspiracy between combination of hospitals accounting for 74% of local market and insurers accounting for 90% of managed care contracts to prevent new specialty hospital from obtaining managed care contracts).

[36] *See* Complaint, *United States v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155 (E.D. Mich. Oct. 10, 2010).

[37] *See* Scott Allen & Marchella Bombardieri, *A Handshake That Made Healthcare History*, BOS. GLOBE, (Dec. 28, 2008) (reporting agreement between dominant insurer, Blue Cross Blue Shield of Massachusetts, and dominant hospital system Partners Health Care pursuant to which Blue Cross would give Partners higher levels of reimbursement, in exchange for Partners' promise that they would demand the same rate increases from everyone else) http://www.boston.com/news/specials/healthcare_spotlight.

Remedies

Although the Department of Justice has settled challenges to a number of insurance industry mergers by requiring divestiture of plans in markets where the merging parties had substantial market shares, such remedies may be problematic in this instance. Research by Professor John Kwoka has demonstrated that divestitures often fail to resolve competitive problems.[38] Moreover, the retrospective studies of the aftermath of the UnitedHealth/Sierra and the Aetna/Prudential merger discussed earlier reveal that the consolidations resulted in significant premium increases in numerous markets.[39] As the Department of Justice has learned in previous cases the task of fully resolving competitive concerns entails finding purchasers of assets that have the incentive and ability to adequately replace the merging insurer. This in turn requires that the merging party guarantee that the purchaser of its assets will have, going forward, a cost-competitive network of hospitals and physicians.[40] Assuring an adequate, cost competitive network of providers necessitates close review of proposed buyers and binding assurances between the buyer and network providers. Whether such settlements are feasible on a large scale is certainly a debatable question. Indeed they create a new layer of regulation and require close monitoring to assure compliance. Moreover, given that such remedies do not address the loss of potential competition from the elimination of two of the largest five insurers in the nation, the Department may well need to "just say no"[41] as it has done in the past.[42]

Developing a Regulatory Agenda to Improve Competition

Despite the many improvements in competitive conditions fostered by the ACA and emerging health industry practices, there are still serious impediments that need to be addressed. As discussed above the problem of dealing with extant market power is certainly at the top of the list. Antitrust law has little to say about monopolies lawfully acquired, or in the case of consummated mergers, entities that are usually impractical to successfully unwind. Given the high level of concentration in many hospital markets, a growing number of physician specialty markets, and insurance markets, it is particularly important to encourage other measures that promote competition. Pro-active, pro-competition governmental interventions may be needed. Second, legislators should reexamine many long standing regulations and reimbursement

[38] John Kwoka, MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S POLICY (2015).
[39] *See supra* note 29.
[40] *See* U.S. Department of Justice, Competitive Impact Statement, *U.S. v. Blue Cross-Blue Shield of Montana* (D. Mont. Nov. 8, 2011) ("To compete effectively in the sale of commercial insurance, insurers need a network of health care providers at competitive rates because hospital and physician expenses constitute the large majority of an insurer's costs.")
[41] *See* David A. Balto, *Health Insurance Merger Frenzy: Why DOJ Must Just Say "No,"* LAW360 (Aug. 17, 2015).
[42] *See* Tom Zanki, *FTC Studies Effects of Divestiture Orders in Mergers*, LAW 360 (Aug. 19, 2015) http://www.law360.com/articles/692989/ftc-studies-effects-of-divestiture-orders-in-mergers.

practices that inhibit vigorous competition among providers and insurers. I discuss below some thoughts on a few specific steps that should be considered.[43]

Although there is no single "silver bullet" to solve the problem posed by extant provider concentration, there are a number of steps that reduce the market power exercised in such markets. To begin with, laws that impose barriers to entry should be amended or repealed. For example, hospital concentration may be lowered in some states by eliminating government-imposed barriers to entry such as Certificate of Need laws. Likewise, state law purporting to limit antitrust scrutiny of provider practices which essentially legalize cartelization of markets should be repealed. There is a strong consensus, based on the nation's experience, that antitrust exemptions harm consumer welfare.[44] Likewise, the 70-year old protections for insurance industry practices contained in the McCarran-Ferguson Act are quite anomalous in today's insurance market.

Obstacles to competitive entry into hospital markets should also be reexamined. Although some restrictions on physician-controlled hospitals are desirable to prevent their "cherry picking" patients, it may be that current law unnecessarily impedes their development.[45] With respect to the delivery of medical services, allowing middle-level professionals, such as nurse practitioners and physician assistants to practice within the full scope of their professional license under state law may increase the number and viability of new organizational arrangements such as patient centered medical homes (PCMH) and accountable care organizations (ACO) that may be able to exert pressure on dominant providers.[46] Finally,

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[43] For a more comprehensive discussion of options for improving market competition *see* American Antitrust Institute, TRANSITION REPORT ON COMPETITION POLICY TO THE 45TH PRESIDENT OF THE UNITED STATES (Forthcoming 2015); Catalyst for Payment Reform, PROVIDER MARKET POWER IN THE U.S. HEALTH CARE INDUSTRY: ASSESSING ITS IMPACT AND LOOKING AHEAD, *available at* http://www.catalyzepaymentreform.org/2013-03-03-06-22-58/2013-03-04-03-29-59/market-power; Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions,* AMERICAN ENTERPRISE INSTITUTE (Jun. 2012), http://www.aei.org/publication/concentration-in-health-care-markets-chronic-problems-and-better-solutions/.

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

[45] *See* Jordan Rau, *Doctor-Owned Hospitals are Not Cherry-Picking Patients, Study Finds*, KAISER HEALTH NEWS (Sep. 3, 2015). *See also* "Patient Access to Higher Quality Health Care Act of 2015" H.R. 976 (proposed legislation to remove restrictions on physician owned hospitals).

[46] The FTC staff has supported legislation expanding the opportunity of complementary providers to compete in several letters to state legislatures. *See e.g.*, Letter from FTC Staff, to the Hon. Theresa W. Conroy, Conn. State Rep. (Mar. 19, 2013), http://www.ftc.gov/os/2013/03/130319aprnconroy.pdf.

because state professional boards have frequently been the driving force behind many anticompetitive regulations,[47] the Supreme Court's recent decision in *North Carolina Board of Dental Examiners v. Federal Trade Commission*,[48] created an opportunity for government enforcers and private plaintiffs to prevent boards from restricting entry and rivalry.[49]

Policies encouraging entry into concentrated insurance markets should also be on a pro-competition regulatory agenda. For example, expansion of insurance pools may trigger new entry. The Arkansas "private option" program for Medicaid expansion allowed the state to cover 220,000 Medicaid beneficiaries with commercial provider plans through its health insurance Marketplace.[50] Not only was the state able to drive down its uninsured rate and reduce uncompensated care costs, it increased competition in its Marketplace as the number of issuers offering plans increased threefold, from two to six. Another unappreciated benefit of Medicaid expansion is the strengthening (and often preservation) of rural and safety net hospitals that serve a large proportion of indigent patients. The demise of these hospitals resulting from failures to expand Medicaid spells less choice and competition for all consumers in their markets.

Payment policies sometimes work at cross-purposes with competition policy. For example, Medicare's provider-based billing rules permit a hospital to bill a facility fee, in addition to a professional charge, for procedures performed by a physician in a hospital.[51] If the same procedure is done in a physician's office or clinic, Medicare does not pay a facility fee. The result is Medicare often pays more for certain procedures when performed in a hospital than when performed in a physician's office or clinic.[52] This provides strong incentives, completely untethered (and likely counter) to improving efficiency, for hospitals to acquire physician practices and to shift the delivery of services to hospital settings.

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[47] Clark C. Havighurst, *Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and Health Care Markets*, 31 J. HEALTH POL., POL'Y & L. 587 (2006).

[48] *N. Carolina State Bd. of Dental Examiners v. F.T.C.*, 135 S. Ct. 1101, 1117, 191 L. Ed. 2d 35 (2015). ("The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies.")

[49] *See e.g., Teladoc, Inc. v. Texas Med. Bd.*, 453 S.W.3d 606 (Tex. App. 2014)(challenge to state board requirement that required in-person visits before administering certain healthcare such as telemedical services).

[50] Jocelyn Guyer *et al*., Kaiser Commission on Medicaid and the Uninsured, *A Look at the Private Option in Arkansas* (August 2015).

[51] *See* CMS, HHS. Revisions to Payment Policies Under the Physician Fee Schedule, 788 No.237 Fed. Reg. 74427, 74228 (Dec. 10, 2013) (to be codified at 42 C.F.R. pt. 405, 401, 411, *et al.*) http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf; *see also* O'Malley, Ann, Amelia M. Bond, and Robert Berenson, *Rising hospital employment of physicians: better quality, higher costs?* Issue Brief No. 136, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (Aug. 2011) http://www.hschange.com/CONTENT/1230/.

[52] *See* Robert Wood Johnson Foundation, HEALTH POLICY BRIEF: SITE-NEUTRAL PAYMENTS, HEALTH AFFAIRS. (July 24, 2014). http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=121.

Finally, it may be possible to strengthen private market participants' ability to negotiate with dominant providers through governmental actions. For example, commercial insurers are currently engaged in testing a variety of devices, such as using tiered networks, reference pricing, and value pricing to incentivize patients to choose more cost-effective providers, equipment, and service options. However dominant providers have insisted on contractual terms (e.g., so called "anti-tiering" clauses) to block such arrangements. Although antitrust law might in some instances prohibit such agreements, more direct, regulatory prohibitions as adopted by several states provides much-needed protections more efficiently. In addition, the lack of price transparency, enforced by provider gag clauses and trade secret law, impede the working of the market. State laws requiring transparency and creating all-payer claims data bases are noteworthy efforts to deal with the problem.[53] The expertise and leverage of agencies regulating insurers might also be called upon. For example, state health insurance exchanges or state regulators might require unbundling of hospital services, as suggested by Professors Havighurst and Richman.[54] For its part, CMS should carefully review the performance of ACOs, and where appropriate, decline renewal of contracts if market power has been exercised over private payers. Likewise, regulations and payment policies that favor ACOs controlled by primary care providers rather than dominant hospitals could serve to reduce the impact of the latter's market power.

Summary

America has chosen, wisely I believe, to rely on competition to spur innovation, assure quality of care, and control costs in the health care sector. Where markets have been allowed to function under competitive conditions—free of anticompetitive regulations, cartels, and monopolies—competition has done its job. Much of the revolutionary change occurring today is designed to improve the function of health care markets and deal with problems of market failure and excessive regulation. In a number of areas however, problems persist. The principle culprits are not found in the provisions of the Affordable Care Act but in longstanding regulations, lax antitrust enforcement, and deference to provider and payor interests. As a result, many markets remain controlled by monopolies, constrained by outdated regulation, and foreclosed to new entrants and ideas from anticompetitive strategies from incumbents. A pro-competition agenda that tackles these problems with pro-competitive regulation would serve the country better than overblown criticisms of the Affordable Care Act.

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[53] *See* Catalyst for Payment Reform, REPORT CARD ON STATE PRICE TRANSPARENCY LAWS (JULY, 2015) HTTP://WWW.CATALYZEPAYMENTREFORM.ORG/IMAGES/DOCUMENTS/2015; Robert Wood Johnson Foundation, *The Basics of All-Payer Claims Databases: A Primer For States*, RWJF (Jan. 2014) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988.

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