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STATE OF COMPETITION IN THE HEALTH CARE MARKETPLACE: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S IMPACT ON COMPETITION

HEARING

BEFORE THE

SUBCOMMITTEE ON
REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

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STATE OF COMPETITION IN THE HEALTH CARE MARKETPLACE: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S IMPACT ON COMPETITION

THURSDAY, SEPTEMBER 10, 2015

HOUSE OF REPRESENTATIVES,

SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW

COMMITTEE ON THE JUDICIARY,

Washington, DC.

The Subcommittee met, pursuant to call, at 10:02 a.m., in room 2141, Rayburn Office Building, the Honorable Tom Marino (Chairman of the Subcommittee) presiding.

Present: Representatives Marino, Goodlatte, Collins, Walters, Ratcliffe, Trott, Bishop, Johnson, Conyers, DelBene, and Cicilline.

Staff present: (Majority) Anthony Grossi, Counsel; Andrea Lindsey, Clerk; and (Minority) Slade Bond, Counsel.

Mr. MARINO. The Subcommittee on Regulatory Reform, Commercial and Antitrust Law will come to order. Without objection, the Chair is authorized to declare recess of the Committee at any time.

We welcome everyone to today's oversight hearing on "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition."

I am going to recognize myself now for an opening statement.

Today's hearing marks the beginning of a series of hearings on competition in the health care marketplace. The first hearing will undertake a broad examination of competition within the hospital, insurance, and physician marketplaces. Additionally, we will also focus on the impact that the Patient Protection and Affordable Care Act, or "Obamacare," has had on competition within each of these sectors.

There is no doubt that there has been significant movement in each of the hospital, insurer, and physician markets since the enactment of Obamacare. Hospital mergers nearly doubled between 2009 and 2013, the period surrounding the congressional debate on Obamacare and immediately after its enactment. Four of the five largest for-profit health insurance companies recently announced their intent to merge, which will be the subject of a separate Subcommittee hearing in the coming weeks. Additionally, reports of

physician practices either merging or being purchased by hospitals has increased in recent years.

On top of all this activity, we are spending more on health care than ever before, and that number is only expected to grow. I trust that competition will put pressure on market actors to deliver quality product at a reasonable price. I have infinitely more confidence in the judgment of a competitive marketplace over the judgment of government.

Obamacare is another government experiment attempting to replace the will of the market with its own. An experiment that, in my view, has gone horribly wrong. As Chairman of the Subcommittee overseeing our antitrust laws in competition, I believe we have a duty to ensure that the laws Congress pass are encouraging competition and that the antitrust laws are being enforced effectively. Today's hearing will help inform Congress of the status of competition in the predominant health care sectors, as well as add to the record of Obamacare's impact on the state of competition in each of these sectors.

I look forward to hearing from our witnesses, and I yield back the balance of my time, and I now recognize the Ranking Member of the Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Mr. Hank Johnson of Georgia, for his opening statement.

Mr. JOHNSON. Thank you, Mr. Chairman.

Today's hearing is the first in a series of hearings that will examine the state of competition in the health care marketplace. It is also the third hearing that this Committee has held on this topic in as many years. But much has changed since our last hearing in September of 2013.

Since the first open enrollment period began in October 2013, the Affordable Care Act has already expanded coverage, savings and protections for millions of American consumers. Since provisions of the Affordable Care Act have taken effect, the law has resulted in the coverage of 16.4 million uninsured people, dropping the uninsured rate by 35 percent, the lowest in 50 years, and lowering the overall cost of health care for both insured Americans and health care providers. It saved 9.4 million seniors more than $15 billion on prescription drugs, or about $1,598 for every beneficiary, and it has dramatically slowed the cost of health care spending, to the benefit of taxpayers and the entire health care system.

The Department of Health and Human Services likewise reported in July that the law has slowed the cost of health care premiums as new competitors in local markets and price competition intensifies. The Congressional Budget Office also reported that these lower premium costs have lowered previous cost estimates for the Affordable Care Act by about $142 billion, or 11 percent, while the Washington Post reports that "the cost of the law has been falling for several years now that analysts are beginning to assess the evidence of the law's impact from its first full year of implementation."

There is also ample evidence that the Affordable Care Act is a reaction to, not a cause of, consolidation in the health care marketplace. A unifying bipartisan theme of our hearings on this topic is that waves of consolidation among health care providers and insur-

ers occurred long before the Affordable Care Act. Whether due to lax antitrust enforcement or bad policy, many local markets were highly consolidated before the enactment of the Affordable Care Act in 2010. According to the Department of Health and Human Services Report on Competition in Health Insurance Marketplaces, competition has intensified across the country as the number of health insurance issuers have increased in most counties. As I have already noted, this increased competition has had the effect of reducing premium growth through an influx of new plans and increased pressure for incumbent insurance issuers to moderate the cost of premiums. Preserving and promoting this competition is critical, and I encourage the antitrust enforcement agencies to do so at every opportunity.

In closing, it is clear that now that we have put it to work, the Affordable Care Act is saving lives and money. Rather than demonizing the Administration and the law that has done so much for so many, we would be ensuring that the progress we have made in such a short time is not jeopardized by anti-competitive behavior or consolidation. With that in mind and notwithstanding the consistently partisan nature of discussions concerning health care and the Affordable Care Act, I thank the Chair for calling this hearing and I look forward to future hearings on this subject. Few topics directly affect the lives of American consumers as ensuring that health care markets are delivering the best and most health care choices in every county in America.

And with that, I would yield back. But let me say before I yield back, I would like to offer into the record, without objection, the statement of Ranking Member John Conyers.

Mr. MARINO. So ordered, without objection.

[The prepared statement of Mr. Conyers follows:]

Statement of the Honorable John Conyers, Jr. for the Hearing on "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition" Before the Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Thursday, September 10, 2015, at 10:00 a.m.
2141 Rayburn House Office Building

Today's hearing will examine the Affordable Care Act's impact on competition in health care markets.

For those of us who care about our Nation's health care system, about the millions of uninsured and under-insured Americans, and about the need to make sure ***all*** consumers of medical services receive good value at affordable prices, today's hearing should be a very beneficial undertaking.

Although the Act has been the subject of at least 60 efforts by the House Majority to repeal it, its impact on competition has been positive.

To begin with, the health insurance exchanges that the Act provides for are designed to foster greater competition and consumer choice among health insurers.

The exchanges make it easier for consumers to compare competing insurance plans and to ensure that such plans are comparable.

So far, the evidence suggests that the exchanges are working as intended. In many markets, on average, at least 6 insurers offered plans, an increase compared to 2014.

And, 86% of eligible individuals had access to at least 3 insurers in 2015, which also represents an increase over the previous year.

Indeed, one might view Anthem's acquisition of Cigna and Aetna's acquisition of Humana as attempts to undermine the health insurance exchanges' pro-competitive effects.

I expect we will gain more insight into that question later this month.

It is also important to note that the Affordable Care Act depends on fair competition between insurers and providers.

One potential obstacle is excessive concentration among hospitals. Consolidation in hospital markets has been occurring at least since the 1990's largely as a result of decades of previously lax enforcement.

The health insurance business, meanwhile, has enjoyed immunity from the antitrust laws in many cases under the McCarran-Ferguson Act of 1945.

Thanks to this exemption, insurers may be allowed to engage in conduct that could harm consumers and care-givers.

That is why I introduced H.R. 99, the "Health Insurance Industry Antitrust Enforcement Act of 2015," on the very first day of the 114th Congress.

My bill would effect a limited repeal the McCarran-Ferguson antitrust exemption for health insurance companies.

Why should insurers be able to engage in price-fixing, bid-rigging, or market allocations, which are the worst kinds of anti-competitive conduct? There is absolutely no sound justification for such an exemption.

If we are to continue with this unwarranted antitrust exemption for health insurance companies, than we should level the playing field by granting a limited antitrust exemption for health providers. That is why I also introduced H.R. 105, the Quality Health Care Coalition Act.

That bill would provide a limited exemption to the antitrust laws for health care providers to collectively negotiate with health insurance plans.

Finally, the Affordable Care Act should lead to greater quality health care services because it encourages coordination, but not consolidation, among health providers.

Among the many concerns with our health care system prior to the Act's enactment was the fact that health care providers could not effectively provide health care services in an efficient and well-coordinated manner.

By encouraging the use of accountable care organizations, the Affordable Care Act encourages pro-competitive coordination and greater efficiency in the provision of health care services.

And, as made clear by statements from both Republican and Democratic members of the Federal Trade Commission, nothing in the Affordable Care Act exempts the application of the antitrust laws to such arrangements.

Accordingly, I thank the Chairman for holding this hearing, which I understand is first in a series of important hearings examining various aspects of competition in health care markets.

And, I thank our witnesses and look forward to their testimony.

Mr. JOHNSON. I yield back.

Mr. MARINO. The Chair recognizes the Chairman of the full Judiciary Committee, Mr. Bob Goodlatte of Virginia, for his opening statement.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Before we begin today's hearing, which marks the beginning of a series of hearings on competition in the health care marketplace, I think it would be helpful to clarify two points of overriding concern.

First, health care is not provided in a true free market, and has not been provided in a free market since at least the onset of major government intervention in the market through Medicare and Medicaid.

Second, health care as a service is unique in that nearly every person in America will require some medical treatment over the course of their lives. Health insurance is not like fire insurance or car insurance, where there is a hope that one will never have to use it. Medical costs inevitably occur and hopefully insurance or some funds set aside for these costs will be used when the time comes.

In the face of these facts—that the health care market is not a fully free market and that Americans have no choice but to participate in the market—it is essential that we preserve as much competition and freedom in the overall health care marketplace as we can.

We should strive to enact laws that foster competition so that prices are checked, patients have choices, and the premium quality of American health care can be maintained. Otherwise, costs will go up, choices will narrow, and quality will be diminished. That is simply the laws of economics at work.

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act, which I believe is antithetical to competition. Rather than promoting free markets, Obamacare put in place a regulatory structure that stifled competition and instituted incentives for increased market consolidation.

Since the enactment of Obamacare, I have been sounding the alarm bells. The Judiciary Committee held hearings on Obamacare and competition in each of the last two congressional sessions. I am pleased that the Committee meets again to continue to sound the siren and supplement the growing record of Obamacare's anticompetitive results.

One of the principal tenets of economics is that competition can lead to lower prices, enhanced product variety, greater innovation, and downward pressure on costs. When markets consolidate, there exists the potential for reduced competition resulting in the contraction of the related benefits.

Of course, consolidation does not always lead to a reduction in competition. Market efficiencies can be obtained, and the expansion of successful products can be achieved more rapidly through transactions. However, when non-market and government forces compel consolidation, those underlying forces and their effects should be closely examined.

Accordingly, it is vitally important that antitrust laws are properly and consistently enforced to prevent anticompetitive consolida-

tion and conduct, and that laws that promote these activities are subject to strict and ongoing scrutiny. Continuous and vigilant oversight, such as at today's hearing, will help to ensure that health care markets operate as freely and competitively as possible, in order to provide consumers with premier and affordable health care.

I look forward to the testimony of our witnesses on the state of competition in the predominant health care markets. Thank you, Mr. Chairman. I yield back.

Mr. MARINO. Thank you, Chairman Goodlatte.

Without objection, other Members' opening statements will be made part of the record.

Now I will begin by swearing the witnesses in. Would you please stand and raise your right hand, please?

Do you swear that the testimony you are about to give before the Committee is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record reflect that all the witnesses have answered in the affirmative.

Please be seated.

We have a distinguished group of witnesses here today that I think are going to contribute a great deal to some of the questions that we would like to have answered.

We will begin with Professor Thomas L. Greaney, who is a Chester A. Myers Professor of Law and Co-Director of the Center for Health Law Studies at the St. Louis University's School of Law. Professor Greaney also is the author of *Health Law*, one of the leading health care casebooks, as well as numerous articles on the intersection of antitrust and health law that have been published in, among other places, the New England Journal of Medicine, the Antitrust Law Journal, the Journal of the American Medical Association, and the Yale Journal of Health Law and Policy.

Prior to joining the St. Louis University School of Law, Professor Greaney served as the Assistant Chief in the Antitrust Division of the Department of Justice. Mr. Greaney received his B.A. magna cum laude from Wesleyan University and his J.D. from Harvard Law School.

Welcome, professor.

Mr. Richard Pollack recently became the 11th President and CEO of the American Hospital Association, known as AHA, on September 1st, 2015. Mr. Pollack has been with the AHA for over 32 years, recently serving as the institution's Executive Vice President for Advocacy and Public Policy, where he was responsible for the development, implementation and management of the Association's advocacy, representation and public affairs activities.

Mr. Pollack started his professional career here on Capitol Hill, serving as a legislative assistant to former Congressman Dave Obey. Mr. Pollack earned his Bachelor's degree in Political Science and Communications from the State University of New York's College at Cortland, and his Master's degree in Public Administration from American University.

Welcome, Mr. Pollack.

Dr. Barbara McAneny was re-elected on June 2014 to the American Medical Association AMA Board of Trustees. Dr. McAneny is

a board-certified medical oncologist and hematologist from Albuquerque, New Mexico, and has served in numerous leadership roles at the AMA. Additionally, Dr. McAneny was appointed by Health and Human Services Secretary Tommy Thompson to the Practicing Physicians Advisory Council from 2002 to 2006.

Dr. McAneny graduated magna cum laude from the University of Minnesota and with honors from the University of Iowa College of Medicine.

Doctor, welcome.

Mr. Dan Durham is the Executive Vice President of Strategic Initiatives at America's Health Insurance Plans, known as AHIP. Mr. Durham has over 30 years of leadership experience with major policy and regulatory issues, primarily in the health care field. In addition to holding senior positions within AHIP, Mr. Durham served in high-level policy positions in the Federal Government, at the United States Department of Health and Human Services, the Social Security Administration, and the Office of Management and Budget.

Mr. Durham received his B.A. from the University of Notre Dame and his Master's degree from Duke University.

Mr. Durham, welcome to you also.

Dr. Scott Gottlieb is a recent Fellow at American Enterprise Institute and a practicing physician. Dr. Gottlieb has served in various capacities at the Food and Drug Administration, including as a Senior Advisor for Medical Technology; Director of Medical Policy Development; and, most recently, Deputy Commissioner for Medical and Scientific Affairs, in addition to serving as a senior policy advisor at the Centers for Medicare and Medicaid Services.

Dr. Gottlieb is also a prolific writer on health care issues, and has been published in leading medical journals and other well-respected periodicals.

Dr. Gottlieb received his B.A. in Economics from Wesleyan University and his M.D. from Mount Sinai School of Medicine of New York University.

Welcome, doctor.

Each of the written statements will be entered into the record in its entirety, and I ask each of the witnesses to summarize his or her testimony in 5 minutes or less. To help you with the timing, you see the lights in front of you. The lights will switch from green to yellow, indicating that you have 1 minute to conclude your testimony. And when the light turns red, it indicates that the witness' 5 minutes have expired.

I do this, and I know that some of you are probably going to do it. We are so intent on saying what we want to say or reading our statements that we pay no attention to those lights, and I will very politely just sort of raise the gavel to get your attention to ask you to please summarize. So, thank you.

With that, Mr. Greaney, would you like to make your opening statement? Would you put your microphone on, sir?

TESTIMONY OF THOMAS L. GREANEY, PROFESSOR OF LAW, ST. LOUIS UNIVERSITY SCHOOL OF LAW

Mr. GREANEY. Thank you very much, Chairman Goodlatte, Chairman Marino, and Ranking Member Johnson.

Mr. MARINO. Could you pull it a little closer to you? It is off to the side.

Mr. GREANEY. I appreciate this opportunity to testify again before this Committee.

Let me summarize my testimony with four key points.

First of all, the Affordable Care Act both depends upon and promotes competition in health care markets. And secondly, while there is no doubt that excessive concentration undermines the competitive policies of the ACA, it is entirely erroneous to claim that the ACA is somehow responsible for this consolidation. Mergers to monopoly and oligopoly are efforts to avoid or frustrate the Act.

Third, the recently announced health insurance mergers threaten competition in a variety of product markets and bear careful scrutiny. The only point I am going to make there is that you should not be taken in by the argument that consumers are somehow better off having big insurers confront big hospitals. I call that the Sumo Wrestler theory.

And finally, my last point is that if state and Federal legislators are concerned about competitiveness of health care markets, as they should be, it is finally time to take a hard look at the real problems that beset the health care market—outdated regulations, anticompetitive practices that can be corrected by procompetitive legislation, and payment incentives that wrongly encourage consolidation. Those are your real culprits, not the ACA.

Okay, let me begin with my first point. The ACA does not regulate prices. It relies heavily on private-sector competition, competition between providers and payers and rivalry within each of those markets. Why do we need government regulation to help competition? Well, let's remember what that putative market, as we like to call it, looked like before health reform. There was a dysfunctional market for individuals and small groups; we had a non-system of service delivery, as hospitals and physicians each operated in their own silos; and we had payment systems that rewarded volume and not outcomes.

What has the ACA done to improve market competition? My written testimony goes into a variety of areas, but most importantly it put in place efficient markets for shopping and bargaining in the individual and small-group market. Very importantly, the exchanges set up mechanisms to shop and compete. And remember that the ACA also put in rules that made insurance products now comparable, understandable, and assure basic levels of coverage. These are Economics 101 conditions for better competition.

What do we have as a result? Well-functioning exchange markets that have enabled over 10 million people to shop for and find products.

The doomsday predictions about the exchanges—risk selection would destroy the exchanges, policies would be unaffordable, employer-sponsored markets would crumble—proved to be wrong, wrong, and wrong.

As to the commercial market, the ACA also has had important salutary effects. First and foremost, it forbid insurers to engage in medical underwriting, going after preexisting conditions. That sent a message to the insurance market that is very important. I want to channel Bill Belichek here. It said "do your job" to insurers, de-

velop health plans that control costs and improve quality rather than chase risk. And widely overlooked is what the ACA did with Medicare reform that is still ongoing. Medicare payment reform emphasizing now value-based purchasing, ACOs and lots of other things, shifted delivery in a very important way, and we know that private commercial markets follow what Medicare does.

So is everything copasetic? No. Unfortunately, concentration is a big problem, but a little history is in order. Much of that, much of the problematic concentration preceded the ACA. The good news is that the DOJ and FTC are on the job and have won a series of important victories that should send a clear message about future consolidation.

I will just mention very briefly my point on insurance sector consolidation since my time is running short. The insurance market consolidation is problematic. It is going to take an in-depth inquiry by the Department of Justice. But the concept—and it is a fallacious one in my view—the idea that somehow we are better off where we pit dominant insurers against dominant hospitals, that is unsupported by the economic evidence, both in theory and in practice. There are lots of antitrust cases where we have seen large insurers and hospitals confronting each other, and they find a way to either conspire with each other, either hurting rivals or simply splitting the spoils of their market power. Sometimes we find out that the sumo wrestlers would rather shake hands than compete.

I listed a long list of ideas for a procompetitive agenda, including things that would help de-concentrate markets. There are a number of steps that could be taken. I commend Dr. McAneny's testimony, which I think gives many of the ideas which I support.

So I think those are the steps that would promote competition and advance the goals of this Committee. [Applause.]

[The prepared statement of Mr. Greaney follows:]

Prepared Statement of
Professor Thomas L. Greaney

Before the

Committee on the Judiciary
United States House of Representatives

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

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[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

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[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).

Mr. MARINO. Thank you, Professor.

Mr. Pollack?

TESTIMONY OF RICHARD J. POLLACK, EXECUTIVE VICE PRESIDENT, ADVOCACY AND PUBLIC POLICY, AMERICAN HOSPITAL ASSOCIATION

Mr. POLLACK. Chairman Marino, Ranking Member Johnson, and distinguished Members of the Committee, on behalf of our Nation's hospitals, I appreciate your inviting me to be here today.

The health care landscape is rapidly changing, and hospitals are helping to lead the way forward. They are focusing on improving the patient care experience, enhancing quality, and lowering the cost of patient care. Many of the market forces reshaping health care were in place long before the passage of the Affordable Care Act, but the ACA has accelerated that pace of change.

A major part of that change is the realignment in the hospital field that I would like to discuss this morning. The emphasis on wellness or population health has encouraged collaboration among providers, along with the development of coordinated care models. These new models are often value-, not volume- or cost-based, which means that providers are at financial risk if they don't achieve specified quality and cost goals.

The Department of Health and Human Services has launched a number of these programs, and by 2018 it expects to move half of all Medicare payments to alternative models of reimbursement that reward value. The Department has also recognized that achieving these goals would require hospitals to make fundamental changes in their day-to-day operations that improve quality and reduce the cost of care.

The hospitals and health systems realigning and transforming care means closely working with other providers to make sure that patients and communities have convenient access to care. That means coordinating with doctors and other caregivers to deliver better patient-centered care; it means hospitals are aligning with other hospitals to unify patient information, better coordinate transitions and follow-up care, and share financial risk, among other improvements; and it means partnering to keep the doors of certain financially failing hospitals open so that patients won't lose access to the medical care they and their community rely on.

For example, a health system in Ohio acquired a small community hospital in bankruptcy that saved 250 community jobs and actually expanded access to care in that rural area, and many small, stand-alone, and rural hospitals are particularly in need of partners. Just the cost of acquiring and maintaining electronic medical records, which can be as much as $50 million for a midsize hospital, can tip the financial balance of these organizations.

Outdated regulatory barriers continue to constrain the pace of innovation, and despite repeated calls for the Federal agencies to modernize these regulations, to date only one has been changed. For example, we have repeatedly asked the Federal Trade Commission, which oversees transactions in the hospital field, for guidance on constructing clinical integration arrangements that could in some instances take the place of mergers. However, we have not received this guidance.

Now, despite these challenges, the results of hospital realignment are promising. It is even impressive. The author of a recent study in the Journal of the American Medical Association used the term "jaw-dropping" to describe the results, which found hospitalizations and costs going down for patients. He observed that there has been tremendous focus on making sure that our hospitals are safer and that treatments are more timely and more effective. Moreover, he acknowledged that the savings per patient did not come at the expense of quality.

And let me highlight just one other fact, and that is that hospital price growth is at historically low levels, less than 1 percent in 2015.

Now, while I understand that this hearing is not focused on the recently announced health insurance acquisitions, I would just like to briefly touch on that point. We have serious concerns about two potential acquisitions and believe they merit the greatest scrutiny from both the Department of Justice's Antitrust Division as well as Congress.

Anthem's proposed acquisition of Cigna, and Aetna's proposed acquisition of Humana, would eliminate two of the largest national health insurance companies, leaving just three dominant national providers of health insurance. That would leave consumers with fewer and, no doubt, more expensive options for coverage, and it would diminish the insurers' willingness to be innovative partners with providers and consumers to transform care.

In conclusion, I just want to say that America's hospitals are woven into the fabric of our communities. Hospitals care for patients when they are sick, and we work to keep communities healthy. We have tried to lead the way and will continue to try to lead the way to reshape the system, to improve quality, to improve efficiency, and to make health care more affordable for patients and families, and we certainly look forward to working with the Committee on making sure that consumers have access to high-quality, affordable care in their communities.

Thank you.

[The prepared statement of Mr. Pollack follows:]

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Testimony of the

American Hospital Association

before the

Subcommittee on Regulatory Reform, Commercial and Antitrust Law

of the

Committee on the Judiciary

of the

U.S House of Representatives

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

September 10, 2015

I am Rick Pollack, president and CEO of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

When the AHA last testified before the House Judiciary Committee in 2012, we began by noting that the health care landscape was changing. At that time, not even we appreciated how much and how fast that environment would change. Market forces continue to rapidly transform the landscape for hospitals and health systems as they work to achieve the Triple Aim – improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. To better serve their communities, hospitals and health systems are integrating with other providers in a variety of ways to ensure more coordinated and patient-centered care and improve efficiency and reduce costs. Hospitals are making progress in all of these areas despite operating in an environment that has enormous capital and regulatory demands and payments linked increasingly to achieving high performance. Meeting these demands often requires significant restructuring for hospitals, all of which has taken place during a period of historically low levels of hospital price growth. (See attached chart at the end of the testimony.)

Contrast that with the recently announced commercial insurance deals – Anthem/Cigna and Aetna/Humana. Those deals appear motivated by top-line profits. The market concentration threatened by the pending insurance deals is large and durable, and consumers and providers are at risk if the deals are allowed to move forward. The two deals promise fewer choices for consumers for commercial insurance and Medicare Advantage (MA) plans, narrower networks of providers in what few choices remain, and higher premiums and/or out-of-pocket costs, among other things. Even if these insurers make good on their promise to reduce costs if they are permitted to consolidate, insurers have a dismal track record of passing any of those benefits on to consumers, and there is no reason to think these deals will be different[i].

The momentum hospitals have established to move our health care system forward also is at risk. Despite their recent claims that they are fostering innovation, these commercial insurers continue to benefit financially from letting hospitals do the hard work of reducing readmissions, improving (rigorously measured) patient quality, experimenting with accountable care organizations (ACOs) and bundling programs, instituting population health programs and numerous other efforts designed to turn a system predicated on volume to one measured by value. There is no reason to believe that allowing these insurers to become even larger and more immune from competitive forces would alter their incentive to sit mostly on the sidelines and reap the considerable financial rewards of provider innovation.

Our testimony focuses on the market forces reshaping the hospital field and how different those are from those that are at work in the proposed commercial insurance consolidations. We also discuss some of the reasons we believe the Department of Justice's Antitrust Division (Department) is likely to find that these deals present an unacceptable risk to consumers.

HOSPITALS ADAPT TO A CHANGING LANDSCAPE TO BENEFIT PATIENTS

Hospitals' Realignment. Hospitals have shouldered much of the heavy burden of reshaping the nation's health care system to meet the laudable goals of improving quality and efficiency and making care more affordable for patients and families. And hospitals have made significant strides toward meeting all of those goals. A July 2015 study, reported in the *Journal of the American Medical Association*, described it as a "medical hat trick:"[ii]

> In this comprehensive analysis of the hospital trends in the Medicare fee-for-service populations aged 65 years and older, there were marked reductions in all-cause mortality rates, all-cause hospitalization rates, and inpatient expenditures, as well as improvements in outcomes during and after hospitalization.

The major forces reshaping the health care system for hospitals are:

- Widespread recognition, especially among those in the hospital field, of the need to replace a "siloed" health care system with a continuum of care that improves coordination and quality and reduces costs for patients;
- Changes in reimbursement models to reward value and encourage population health;
- Increased capital requirements; and

- Competition that is rapidly changing how services are delivered.

Building a Continuum of Care. Our 2012 testimony detailed some of the pivotal events that led the hospital field to begin in earnest replacing a health care system characterized by uncoordinated silos of care with one that provided patients with a continuum of care. That work has continued unabated.

Building a continuum demands that providers be more integrated. Integration can take many forms – hospitals, physicians, acute-care providers and others in the health care chain can integrate clinically or financially, horizontally or vertically, and the relationships can range from loose affiliations to complete mergers – and it is happening across the country. For example, a large teaching hospital in Virginia is partnering with other hospitals in the state to form a regional health care system stretching into Northern Virginia; a New Orleans health system is partnering with four other hospitals across the state to launch a network to provide patients with access to 25 medical facilities and more than 3,000 physicians; and hospitals in Michigan partnered to create a regional affiliation allowing a critical access hospitals' patients access to the full array of services offered by the larger system.

Hospitals and patients benefit when a hospital realigns. The most common benefits are improved coordination across the care continuum, increased operational efficiencies, greater access to cash and capital for smaller or financially distressed hospitals and support for innovation, including payment alternatives that entail financial risk. For financially struggling hospitals, finding a partner can make all the difference. For example, a health system in Ohio acquired a small, community hospital in bankruptcy with closure impending, which saved 250 community jobs, increased technological efficiencies and expanded access to care in the rural area. The acquisition by a nearby hospital system of a hospital that was struggling financially led to it being transformed into a much-needed regional children's hospital, which provided improved access and services for area children.

Regulatory Barriers Persist for Integration. While innovative partnerships and integrative arrangements abound throughout the country, permanent arrangements, such as mergers, offer the most protection from a staggering array of outdated regulatory barriers that make integration risky when Medicare or Medicaid patients are involved. Despite the AHA having identified the five main barriers to clinical integration more than 10 years ago, to date, only one regulatory barrier has been addressed. The following barriers remain:

- Lack of antitrust guidance on clinical integration (current guidance applies only to arrangements that are part of the Medicare Shared Savings Program, better known as ACOs);
- Restrictions on arrangements that base payments on achievements in quality and efficiency instead of just hours worked (Stark Law);
- Restrictions on financial incentives to physicians that could be construed as influencing care provided, even if the goal of the incentive is to adopt proven protocols and procedures to improve care (Anti-kickback law); and

- Uncertainty about how the Internal Revenue Service will view payments from tax-exempt hospitals to non-tax exempt physicians working together in clinically integrated arrangements.

It is notable that all these barriers to clinical integration had to be addressed to allow the ACO program to move forward. Yet, the federal agencies responsible for administering these laws and regulations have yet to modernize them, with one limited exception, to support even more progress toward building a continuum of care through innovative arrangements like those described above.

MOVING TO A VALUE-BASED REIMBURSEMENT SYSTEM

Increasingly, reimbursement models are being recast to compensate providers based on outcomes, not the volume of services provided. The outcomes being rewarded include keeping patients well (population health) and providing high-quality services when patients are in the hospital.

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve higher quality care at lower costs. These reforms include forming ACOs, bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. The Centers for Medicare & Medicaid Services (CMS) recently announced a goal of moving 30 percent of Medicare payments to alternative models of reimbursement that reward value by 2016 and to 50 percent of payments by 2018. In its announcement, CMS recognized that achieving these goals would require hospitals to "make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care."

Hospitals have supported these efforts and often take the lead in testing and improving them. In addition, hospitals are collaborating with and learning from each other in order to improve the quality of care they deliver to patients. For example, the Health Research & Educational Trust (HRET), an AHA affiliate, was awarded a contract by CMS to support the Partnership for Patients campaign, a three-year, public-private partnership designed to improve the quality, safety and affordability of health care for all Americans. The AHA/HRET Hospital Engagement Network project helped hospitals adopt new practices with the goal of improving patient care and reducing readmissions by 20 percent. The project, which included a network of nearly 1,500 hospitals across 31 states, focused on several areas of impact and produced cost savings of $988 million through improved care. Some additional highlights include: a 61 percent reduction in early elective deliveries across 800 birthing hospitals; a 48 percent reduction in Venous thromboembolism (blood clot in a vein) across 900 hospitals; and a 54 percent reduction in pressure ulcers across 1,200 hospitals.

Meanwhile, many hospitals report that it has been difficult to work with commercial insurers in moving to new payment models. We recently surveyed members of AHA's nine regional policy boards, which represent hundreds of hospitals around the nation, about their experience working

with commercial insurers on new payment models. About 80 percent reported it was a challenge to work with insurers on new payment models, and more than 40 percent described it as a major challenge.

INCREASED CAPITAL REQUIREMENTS

The fundamental restructuring that CMS anticipates in response to its alternative reimbursement models will undoubtedly come with a high cost that will be particularly difficult to bear for small and stand-alone hospitals. Already, the field is under serious financial pressure from the need for capital expenditures, particularly those for health information technology (IT) and electronic health records (EHRs). In fact, the AHA estimates that hospitals collectively spent $47 billion on IT, including EHRs, each and every year between 2010 and 2013.

EHRs are essential to improving care and, consequently, succeeding in value-based reimbursement models. Every hospital is expected to meet a constantly evolving set of standards for having and using EHRs for their patients. And a portion of Medicare and Medicaid reimbursement is conditioned on EHR adoption and use. Estimates are that EHRs will cost a hospital between $20 and $200 million depending on their size. For smaller, rural and stand-alone hospitals, these costs can be ruinous without a partner to absorb some of the cost and provide the necessary technical expertise.

For many hospitals, the credit markets are already difficult to access. The most recent FitchRating report confirms this; starting in 2011, the profitability "metrics" for the lowest rated hospitals has declined.[iii] The lowest rated hospitals tend to be smaller or stand-alone. The debt burden for the lowest rated hospitals also has continued to grow, and the hospitals' operating margins are razor thin. For these hospitals, accessing the credit markets for capital improvements, including technology, will be difficult, if possible at all. Without a partner, these hospitals will continue to decline until they are forced to close their doors, with potentially devastating repercussions for the communities they serve.

NEW COMPETITION FOR HOSPITAL SERVICES

Rapid changes in the health care market are providing consumers with an increased array of options for their health care, including services that hospitals provide.

CVS, Walgreens and Wal-Mart, among others, are changing where consumers go for their health care needs. The retailers offer an array of health care services, including primary care, immunizations, blood pressure monitoring and routine blood tests, all of which were formerly available only in a doctor's office or hospital outpatient clinic or emergency room. Meanwhile, many of the retailers have ambitions to provide even more sophisticated care and services at their thousands of convenient locations. These developments challenge hospitals to become more integrated with physicians and other providers so that they too can offer convenient and more affordable care that is attractive to patients.

Telehealth promises to revolutionize how an incredible array of health care services are provided to consumers and to change the competitive landscape entirely. Telehealth is already delivering services as different as dermatology and mental health to patients across town and across the country. A hospital in Arlington, Va., has an arrangement with the Mayo Clinic, which is based in Rochester, Minn., that allows its patients access to Mayo's expertise without leaving the neighborhood. A hospital system in California was able to cover its needs for physician intensivists at one of its satellite facilities using mobile telehealth devices instead of hiring new doctors, with positive clinical and patient satisfaction outcomes. Increasingly patients are able to consult doctors using their computers, laptops and smartphones, and this is becoming a more common expectation of patients when they seek care. For their part, insurers too are increasingly relying on telehealth to reduce costs and meet network adequacy requirements. All of this changes the competitive landscape for hospitals. Now, competitors for even specialized services do not have to be in the same neighborhood, city or state to connect with patients that might otherwise have sought care at their local hospital.

The rapid growth of telehealth illustrates how quickly the competitive landscape can change for hospitals and the importance of having adequate financial resources and access to capital. Without those resources, hospitals cannot keep up with the demands of new technology or the opportunities they present.

SERIOUS CONCERNS ABOUT HEALTH INSURANCE CONSOLIDATION

The AHA has serious concerns about the recently announced health insurance consolidation: Anthem with Cigna and Aetna with Humana. These deals would eliminate two of the largest national health insurance companies, leaving just three dominant providers of health insurance. A recent study in *Technology Science*, highlighted why this increasing concentration should be of particular concern. It found the largest issuer in each state not only raised premiums higher, but also raised premiums on more of their plans than other issuers in the same state.

In separate letters to the Department, AHA detailed the hospital field's concerns about the deals. The two letters are available at *www.aha.org/letters*, and we briefly outline our concerns below.

The Anthem Deal Threatens to Reduce Competition on a Massive Scale. The Anthem/Cigna transaction threatens to reduce competition in at least 817 markets across the U.S. serving 45 million consumers. This estimate uses the same concentration index – the Herfindahl-Hirschman Index (HHI) – as the federal antitrust agencies. The high barriers to entry in the health insurance market exacerbate this massive concentration. A former Acting Assistant Attorney General described entry as "difficult," particularly in concentrated markets like those at issue in this transaction.

Claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. In addition, neither of the

legislated controls on excessive premium hikes – medical loss ratio (MLR) or rate review – are sufficient to prevent Anthem from raising rates to consumers above competitive levels.

The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. The MLR thresholds are set at 85 percent for large group health insurance coverage and 80 percent for small group coverage. Despite its seeming promise, the MLR will not be effective in controlling premium cost increases because: the MLR requirements apply to fewer than 50 percent of Americans under 65 with health insurance coverage; the rules for reporting MLRs may mask differences in premiums rate increases; and the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities.

Likewise, insurance rate review will not prevent rate hikes. Neither the Department of Health and Human Services nor most states have the power to prevent a rate hike. For example, an article in the August 27 *Wall Street Journal* reported that officials had "greenlighted" hikes in health insurance rates of more than 36 percent in Tennessee, 25 percent in Kentucky and 23 percent in Idaho.

Lastly, Anthem's affiliation with the Blue Cross and Blue Shield (Blue) system raises some particular competitive concerns that we urge the Department to examine closely as part of its comprehensive investigation. An August 2015 letter from Joe R. Whatley, Jr., to the Department described the BCBSA License Agreement that prevents the individual Blues from directly competing against one another, and also prevents their non-Blue subsidiaries from competing even slightly vigorously against other Blue companies. The letter stated:

> Because Anthem cannot expand its non-Blues business, an evaluation of the effects of its merger with Cigna must include not only those geographic markets in which Cigna competes with Anthem, but also those geographic markets where Cigna competes (or would compete) with any other insurers. In each of those markets … Cigna can no longer compete for new business in any market unless it decreases its business by an offsetting amount in another market. The net effect is that Cigna's effectiveness as a competitor … will be impaired.

The letter may only have partially captured the extensive interconnections between Anthem and the other Blue Card members that appear likely to eliminate competition between Cigna and every Blue plan in every state. In fact, the letter may understate the coordination likely to result between Cigna and the non-Anthem Blues plans.

As a result of the folding of Cigna into the overall Blue system through Anthem Blues' affiliation, this merger may augment the already considerable power of the Blue plan in every state. American Medical Association data report that Blues plans tend to be the most dominant plan in virtually every state in which they operate. Because of the way in which the Blue system operates, Blues plans nationwide may now be able to control Cigna lives, particularly for BlueCard members including national employer accounts, as their own when they negotiate with providers for rates, terms, and conditions under which coverage is available to consumers. If so, this would give these Blues plans even more market power to block entry into their local markets and to constrict plan

design and reimbursement rates, by, for example, further narrowing provider networks available to consumers and/or driving down rates for those in the network below competitive levels and causing some to decline to participate in any network. The Blues' control over provider reimbursement would increase their ability to put new and potentially expanding competing health plans at a competitive disadvantage by depriving providers of the flexibility and options to work effectively with those new insurance competitors.

At a time of rising health insurance premiums, the Department and state Attorneys General should take a close look at how this acquisition could increase Blue plan dominance nationwide. Blue Cross dominance has been an issue the Department has been concerned about in previous health insurance consolidations. In a speech by former Assistant Attorney General Christine Varney, she noted that local health plan dominance (i.e. Blues plan dominance) creates barriers to entry. And, the department has challenged two Blue plan mergers that would have increased that dominance. Given the size and scope of this deal and the dominance of the Blues plans nationwide, the Department should thoroughly investigate how the addition of Cigna to the Blues' arrangement could further entrench that widespread dominance and result in less competition, fewer practicing providers and higher consumer premiums.

Aetna's Deal with Humana Could Further Concentrate MA Markets Already Suffering from a Lack of Competitive Alternatives. More than 2.7 million seniors are enrolled in MA plans operated by the companies in more than 1,000 markets that would become highly concentrated if Aetna is permitted to acquire Humana (this estimate uses the HHI). The deal will not only eliminate current competition between Aetna and Humana in the MA market, it also will eliminate the possibility of future competition between them. Humana is the second largest MA insurer and Aetna the fourth.

This is particularly concerning as there is almost a complete lack of competition in MA markets, according to an August 2015 report by the Commonwealth Fund, which states that "97 percent of the [MA] markets in U.S. counties are highly concentrated." This confirms a recent report by the Kaiser Family Foundation that also describes MA markets as highly concentrated. That report also notes that while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

The Department has viewed MA as a separate product market because of its unique characteristics. Both lower out-of-pocket costs and a more extensive benefit design have distinguished it from traditional Medicare. While payments to MA plans have moderated, the financial protection and greater range of benefits offered by MA plans continue to attract seniors in large numbers, despite predictions that lowered payments would have the opposite effect. Today, almost one in three Medicare beneficiaries are enrolled in an MA plan, amounting to 16.8 million people.

The high barriers to market entry and lack of efficiencies present in the Anthem deal are present here as well. The remedy the Department has relied on in previous health insurance deals – a series of MA plan divestitures – is unlikely to be sufficient to remediate the likely competitive harm from this deal. Even if it were feasible, it would be a staggering task to develop, implement

and supervise these divestitures in a manner that did not further erode the competitive equilibrium in these markets.

CONCLUSION

Hospitals are woven into the fabric of their communities, and as such, they know what their patients need and how to deliver that care at lower costs while improving quality. At the same time, hospitals are adapting to the enormous change that is occurring in the health care landscape because they know yesterday's health care system will not meet the nation's current and future health care needs. This is why hospitals are coming together with other providers to provide patients with high-quality, well-coordinated care, and it is contributing to lower cost growth. On the other hand, the recently announced commercial insurance deals will not benefit consumers. Instead, they will lead to further consolidation of an already highly concentrated health insurance market, fewer choices for consumers for commercial insurance and MA plans, and higher premiums and/or out-of-pocket costs.

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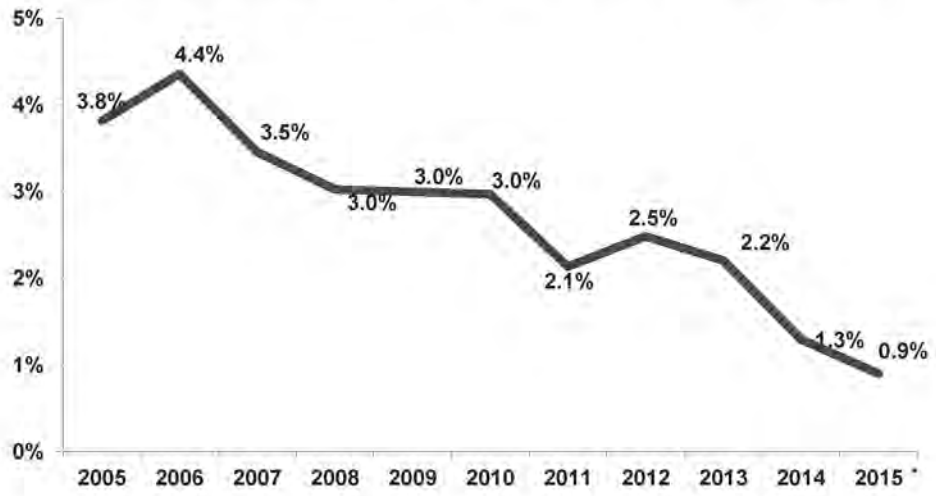
[i] Paying a Premium on Your Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry, Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan. American Economic Review 2012, Volume 102, No. 2.

[ii] 'Jaw-dropping': Medicare deaths, hospitals AND costs reduced, USA Today, July 28, 2015. Reporting on "Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years and Older, 1999-2013", Krumholz, Nuti, Downing, Normand & Wang, JAMA, July 28, 2015, Vol. 312, No. 4.

[iii] FitchRatings, 2015 Medium Ratios for Nonprofit Hospitals and Health Systems, Special Report, August 10, 2015.

The annual growth in hospital prices has been low and declining.

Annual Percent Change in Hospital Prices, 2005-2015*



Bureau of Labor Statistics. Producer Price Index data, 2014-2015, for Hospitals (622)
*Hospital price percent change in 2015 is from July of 2014 to July of 2015.

American Hospital Association.

Mr. MARINO. Thank you, Mr. Pollack.
Dr. McAneny?

TESTIMONY OF BARBARA L. McANENY, M.D., MEMBER OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. MCANENY. Thank you. Good morning. I am Dr. Barbara McAneny. I am a cancer doctor practicing in New Mexico, and I am immediate past chair of the American Medical Association. Thank you for inviting us to participate in this oversight hearing on competition in the health care marketplace.

Physicians want to participate in a health care delivery system that allows us to deliver high-quality and efficient care to our patients. We believe that competition between and among health care providers, facilities and insurers is an excellent prescription for achieving that goal.

The Affordable Care Act, which includes provisions that are designed to stimulate competitive forces in segments of the health care market, is a disruptive force whose impact is still being revealed. New payment and delivery models focusing on quality and efficiency can foster competition by encouraging innovation. Physician leadership in these new models is critical both to protecting patients' interests and driving down costs.

Indeed, preserving the ability of physicians to participate in alternative payment models, including small or specialty or rural practices, is essential because it ensures patient choice, preserves the doctor-patient relationship, and provides better competition in health care markets. Therefore, we recommend reassessing and removing legal barriers that inhibit physician engagement.

Specifically, we strongly support the FTC and DOJ efforts to clarify the application of antitrust laws and urge additional guidance to encourage the development of physician-guided, innovative delivery models. Currently, broad prohibitions under the Federal fraud and abuse laws discourage physicians from adopting innovative incentive programs that could kick-start competition. We therefore urge Congress and the Administration to strengthen and expand program integrity exemptions for physicians participating in alternative delivery and payment models.

Ultimately, physicians should be able to maintain independent practices and participate in innovative care models. Anticompetitive hospital markets may undermine the incentive of hospitals to compete based on quality, potentially laying the groundwork for suboptimal care. Lifting the ban on new physician-owned hospitals, which have developed an enviable track record on quality and cost, offers one way to inject new competition into hospital markets.

Similarly, we believe that competition, not consolidation, is the right prescription for health insurer markets. Competition can lower premiums, enhance patient care, and spur innovative ways to improve quality while lowering costs. Our annual study of commercial health insurance markets shows that 70 percent are already highly concentrated. We believe that there must be a rigorous review of proposed mergers to determine their effects on competition and their consequences for patient care.

In 2010, the Department of Justice found that the proposed Blue Cross merger in Michigan would have resulted in "the ability to

control physician reimbursement rates in a manner that could harm the quality of health care delivered to consumers." The same analysis should be applied to pending mergers.

In practice, the concentration of market power among a handful of nationwide insurers impacts physicians' ability to facilitate individualized care. Doctors are left with no recourse to advocate for our patients, and innovation is stifled. Market dominance does not produce patient benefits when physicians are squeezed and networks are narrowed. Patients should be able to select their doctors based on quality and service, and doctors should be free to get patients what they need and deserve. This is a stark reminder of what is at stake: the health and safety of American patients.

We are at a critical decision point on health insurance mergers because once the handful of national players is further reduced, there is simply no going back. Post-merger remedies are likely to be both ineffective and highly disruptive. Thus, we believe that the time for heightened scrutiny and careful consideration is now, before proposed mergers take effect and result in a fait accompli wherein patients and physician practices are permanently harmed.

Competition plays a major role in enabling patients to access the high-quality care they deserve at a reasonable cost. We thank the Subcommittee for your continued efforts on this issue, and we look forward to working with you to improve health care competition. Thank you.

[The prepared statement of Dr. McAneny follows:]

TESTIMONY

of the

American Medical Association

before the

Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

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

Presented by: Barbara L. McAneny, MD

September 10, 2015

Division of Legislative Counsel

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STATEMENT

of the

American Medical Association

to the

Committee on the Judiciary
Subcommittee on Regulatory Reform,
Commercial and Antitrust Law
United States House of Representatives

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

September 10, 2015

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on competition in the health care marketplace and the consequences of market consolidation. We commend Chairman Marino and Members of the Subcommittee for addressing these important antitrust issues. Our comments examine health insurer consolidation, hospital consolidation, and antitrust and regulatory barriers to fostering competition in the health care marketplace. We believe that there must be a rigorous review of proposed mergers to determine their effects on competition and their consequences for consumers and health care providers. We urge the Congress and the Administration to reexamine current antitrust and program integrity laws and regulations to ensure they effectively foster, as opposed to unduly inhibit, competition in the health care marketplace. Over forty years ago, Senator Philip Hart opened hearings on health care competition with the question, "Isn't it just possible, some are asking, that turning competition loose…may not only lower the costs of health care but improve

its quality?"[1] We believe that Senator Hart's query remains just as vital today, and look forward to working with you on this important effort to leverage competition for the benefit of Americans' physical and fiscal health.

FOSTERING COMPETITION IN THE HEALTH CARE MARKETPLACE

The AMA strongly supports and encourages competition between and among health care providers, facilities, and insurers as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more choices for health care services and coverage stimulates innovation and incentivizes improved care, lower costs, and expanded access. In keeping with this commitment, the AMA has long advocated for physician leadership in new payment and delivery models that focus on quality and efficiency. We believe that physician leadership in these new models is imperative to their success, and offers the greatest potential both to protect patients' interests and to incur lower costs.

The competitive effects of the Patient Protection and Affordable Care Act (ACA) are still being revealed. The law's support for new integrated delivery systems provides meaningful opportunities for physicians to compete and improve quality, but it is not yet clear whether continuing barriers to market entry can be overcome to achieve the underlying goals of the legislation.[2] Notably, the Medicare Access and CHIP Reauthorization Act, or MACRA, which was signed into law on April 16, 2015, provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment.[3] Thus, MACRA builds on provisions in the ACA intended to incentivize stakeholders in the health care marketplace to seek new payment and delivery models with the potential to improve the coordination, quality, and value of care. The creation and incubation of new delivery systems was one of the key ways in which the ACA sought to promote competition, a goal that is undermined by non-competitive markets.[4]

Under MACRA, physicians with sufficient revenue or patients related to qualifying alternative payment models (APMs) will receive a five percent bonus in 2019 through 2024, and slightly higher payment updates beginning in 2026. Qualifying APMs will include Center for Medicare and Medicaid Innovation (CMMI) models (other than health care innovation awards), accountable care organizations (ACOs) under the Medicare Shared Savings Program (MSSP), Health Care Quality Demonstration Programs, and demonstrations required by federal law. A

[1] Senator Philip A. Hart, Hearings Before the Subcomm. on Antitrust & Monopoly of the Senate Comm. on the Judiciary, 93rd Cong., 2nd Sess. 1 (1974).
[2] Thomas Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo*, 89 OR. L. REV. 811, 839 (2011).
[3] The AMA's section-by-section summary of MACRA is *available at*: https://download.ama-assn.org/resources/doc/washington/x-pub/2015-05-07-hr-2-detailed-summary-branded.pdf.
[4] Greaney, *supra* note 2, at 839.

new Physician-Focused Payment Model Technical Advisory Committee will make recommendations on physician-focused payment models.

Properly-structured APMs can foster competition in several ways. When payments are made for larger "bundles" of services, they give physicians greater flexibility to design their care in the most effective and efficient way, rather than being constrained to deliver only the specific services which are eligible for payment. This enables development of more innovative approaches to care delivery, which in turn will result in more and better choices for patients. As such, the AMA recently recommended to CMS that instead of mandating participation in its proposed Joint Replacement Payment Model[5] based on randomly selected geographic regions (thereby precluding participation in other parts of the country), the Agency should define the model as an eligible APM under MACRA. Only through a collaborative approach that achieves provider buy-in can lasting and meaningful health care delivery reform be accomplished. Tomorrow's "disruptive solution" starts with a cultivation process that is typically small and local, not mandated through a top-down command process circumscribed by arbitrary geographic and temporal restrictions.[6]

Antitrust Barriers to Physician Engagement in New Payment and Delivery Models

To promote greater physician participation in APMs, especially by small and specialty practices, we believe the legal and regulatory framework for new care models must allow and encourage flexibility. Under antitrust law, physicians generally may not collaborate regarding payer negotiations unless they are integrated, either financially or clinically. While some innovative delivery systems have sought and obtained conditional antitrust clearance from the Federal Trade Commission (FTC) pursuant to a showing that they are clinically integrated, the current enforcement policies regarding physician network joint ventures are unnecessarily restrictive, require costly complex infrastructure, and are ultimately prohibitive to physician participation in new delivery models.[7] This rigidity may prevent physicians from leading APMs and producing the considerable benefits that would otherwise accrue, leaving hospitals and very large health systems as the only players in the market. The latter consequence will likely exacerbate the problem of hospital market dominance and acquisition of physician practices.

The FTC and the Department of Justice (DOJ) have recognized this problem and provided some much-needed relief by clarifying the application of antitrust laws in their Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the MSSP.[8] The AMA strongly supports

[5] 80 Fed. Reg. 41197-41316 (July 14, 2015).
[6] *See* Clayton Christiansen et al., *The Innovators Prescription: A Disruptive Solution for Healthcare*, McGraw-Hill (2008).
[7] *U.S. Dep't of Justice and Fed. Trade Comm'n, Statement of Antitrust Enforcement Policy in Healthcare* [Healthcare Statements] (1996) at 8, *available at*: www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf).
[8] 76 Fed. Reg. 67026-67032 (October 28, 2011). The Agencies' final statement is *available at*: http://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf.

this effort and encourages the FTC and DOJ to consider additional clarifying guidance for other models, especially those developed by the CMMI. Moreover, the trend toward value-based reimbursement supplies an important opportunity for the FTC to modernize the 1996 Healthcare Statements by expanding the application of the concept of "financial integration." Specifically, the Agencies should explicitly recognize that physician networks engaged in APMs and producing benefits that would not otherwise accrue are "financially integrated" and can lawfully engage in joint negotiation of fees.

The AMA has continually advocated that the Agencies set forth clear and commonsense antitrust rules concerning the formation of innovative delivery models so that physicians can pursue integration options that are not hospital driven. Physicians should not have to become employed by a hospital or sell their practice to a hospital in order to participate in innovative delivery models. Ultimately, physicians should be able to maintain their independent practices while at the same time have access to the infrastructure and resources necessary to participate in APMs.

Program Integrity Barriers to Physician Engagement in New Payment and Delivery Models

We also believe that clarification of program integrity laws would help promote innovative arrangements that pose little risk of fraud and abuse, especially the overly broad prohibition against gainsharing arrangements. Allowing more flexibility in gainsharing arrangements could promote APMs that provide cost savings and improve efficiency. We urge Congress and the Agencies to examine ways to modernize existing laws and requirements to reflect a more coordinated approach to delivering care.

Indeed, in its proposed rule on the 2016 Medicare Physician Fee Schedule, CMS explicitly recognized stakeholder concerns regarding the impact of the self-referral regulations on health care delivery and payment reform.[9] As CMS noted, significant changes in health care delivery and payment have occurred since the enactment of the self-referral law, including numerous initiatives to align payment under Medicare, Medicaid, and non-federal programs with the quality of care delivered. Physician leadership in these new efforts is instrumental to optimizing care, improving population health, and reducing costs.

However, outside of models for which the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has explicitly established waivers of the federal program integrity laws, physicians may be wary of pursuing participation in innovative delivery and payment models due to real or perceived prohibitions under the compensation standards of the self-referral regulations. In particular, the narrowness of the self-referral exceptions with respect to physician compensation arrangements can make it exceedingly difficult to structure incentive

[9] 80 Fed. Reg. 41927-41930 (July 15, 2015).

payments tied to quality improvement criteria. In fact, the Government Accountability Office (GAO) has found that stakeholders' concerns about the legal framework for program integrity "may hinder implementation of financial incentive programs to improve quality and efficiency on a broad scale."[10]

Unfortunately, the OIG waivers for physicians who participate in the MSSP for ACOs are overly narrow. Much like the aforementioned FTC and DOJ antitrust policy clarifications, moreover, they are limited to the MSSP and exclusive of other APMs.[11] The AMA believes that lawmakers and regulators should consider expanding these exemptions to encourage other forms of innovative delivery and payment models. Specifically, we have encouraged CMS to publish guidance regarding the waiver of federal program integrity laws for those physicians participating in programs developed by the CMMI. Programs run by the CMMI pose little risk of fraud and abuse because they have built-in safeguards, including careful monitoring by CMS. For CMMI's programs to succeed, physicians and other participants need to fully assess how care can and cannot be provided to patients under these new models. Without bright line guidance, program integrity provisions can deter the adoption of payment and delivery reforms, including bundled payments, medical homes, and other initiatives. Currently, CMMI has addressed the applicability of fraud and abuse laws through the contract process on a case-by-case basis. Program applicants therefore do not have up-front guidance regarding the challenges and restrictions that will apply.

Overall, current broad prohibitions under the fraud and abuse laws discourage physicians from using innovative incentive plans and other arrangements to improve care quality and reduce costs. More explicit and predictable guidance on when an arrangement will or will not prompt action under the fraud and abuse laws could have the dual effect of safeguarding against patient or program abuse while facilitating desired delivery system reform.

HEALTH INSURER CONSOLIDATION

The AMA believes that competition, not consolidation, is the right prescription for health insurer markets. Competition can lower premiums and incentivize insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

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[10] Government Accountability Office, Medicare: Implementation of Financial Incentive Programs under Federal Fraud and Abuse Laws. Report 12-355 (March 2012), *available at:* http://www.gao.gov/products/GAO-12-355.
[11] 76 Fed. Reg. 67992-68010 (November 2, 2011).

Health Insurance Markets are Mostly Highly Concentrated

Competition is likely to be greatest when there are many sellers, none of which has any significant market share. Unfortunately health insurance markets are mostly highly concentrated, meaning that typically there are few sellers and they possess significant market shares.

Commercial Health Insurance

For the past 14 years, the AMA has conducted the most in-depth annual study of commercial health insurance markets in the country. The AMA's most recently published study, *Competition in Health Insurance: a Comprehensive Study of US Markets* (2015 update), is intended to help researchers, policymakers 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 AMA's analysis shows that there has been a near total collapse of competition among health insurers, with seven out of ten metropolitan areas rated as highly concentrated based on the DOJ and FTC Horizontal Merger Guidelines (2010) (Merger Guidelines) used to assess market competition. Moreover, 38 percent of metropolitan areas had a single health insurer with a commercial market share of 50 percent or more.

Further AMA analysis shows the proposed Anthem-Cigna merger would be presumed under the Merger Guidelines to be anticompetitive in the commercial, combined HMO+PPO+POS markets in 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO NV, KY) in which Anthem is licensed to provide commercial coverage. In the remaining four states (OH, CA, NY, WI), the merger would potentially raise significant competitive concerns and warrant scrutiny under the Merger Guidelines.

There may also be a national market in which health insurers compete or potentially compete for the contracts of large national employers. In that market there are only five national health insurance companies remaining today: Anthem, CIGNA, Aetna, Humana and United Healthcare. The proposed Anthem/Cigna and Aetna/Humana mergers would pare the number of national players to three.

Medicare Advantage

The AMA's study does not cover the Medicare Advantage markets where the merger of Humana and Aetna will be felt. However, competitive conditions in Medicare Advantage markets appear to be even more troubling than in the commercial health insurance market studied by the AMA. According to a Commonwealth Fund study published last month, 97 percent of Medicare Advantage markets are highly concentrated and therefore characterized by a lack of

competition.[12] The proposed merger of Humana and Aetna would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna) to form the largest Medicare Advantage insurer in the country.[13]

The Need for Antitrust Scrutiny of Health Insurer Mergers

Based on past experience, the AMA believes it is critical that the DOJ, FTC, and state attorneys general carefully consider the consequences of the proposed megamergers in the health insurance industry. Specifically, we believe it is important to evaluate the potential effects on both (1) the sale of health insurance products to employers and individuals (the sell side), and (2) the purchase of health care provider (including physician) services (the buy side).[14] The proposed megamergers may pose a threat of anticompetitive effects in both the local and national markets in which individuals and employers purchase insurance. The mergers also could enable the merged entities to lower reimbursement rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients. Thus, the AMA believes that high insurer market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power poses a substantial risk of harm to consumers.

Likely Detrimental Effects for Consumers in the Health Insurance Marketplace

Given the present structure of the health insurance market, health insurers have the ability unilaterally or through coordinated interaction to exercise market power by raising premiums, reducing service, or stifling innovation. Accordingly, health insurer markets require more, not less, competition and mergers must be carefully scrutinized.

The need for merger antitrust scrutiny is illustrated by the evidence concerning the effects of past health insurance mergers on premiums. For example, a study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.[15] Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the

[12] B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.
[13] Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, *available at*: http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/.
[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*; *U.S. v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), *available at*: www.usdoj.gov/atr/cases/f213800/213815.htm.
[15] Leemore Dafny et al., "Paying a Premium on your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review* 2012; 102: 1161-1185.

merger, premiums in Nevada markets increased by almost 14 percent relative to a control group.[16]

Lost competition through a merger of health insurers is likely to be permanent, and acquired health insurer market power would be durable, because barriers to entry prevent new entrants from restoring competitive pricing to concentrated markets. These barriers include state regulatory requirements; the need for sufficient business to permit the spreading of risk; contending with established insurance companies that have built long-term relationships with employers and other consumers; developing a healthcare provider network; and overcoming the brand-name acceptance of established insurers.[17]

Health Insurer Mergers in Concentrated Markets are Unlikely to Generate Consumer Benefits

One possible rationale for the health insurer megamergers now proposed is that the mergers are needed to generate efficiencies that will ultimately benefit consumers. Such a claim, though, is refuted by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in higher, not lower, insurance premiums. One explanation for this result is that health insurers lose the incentive to pass along cost savings to consumers, both because they face little if any competition and because the demand for health insurance is inelastic—when the price is raised, the insurer's total revenue increases, and when price falls so do total revenues.[18]

Several scholars have observed that one of the motivations for the health insurer mergers is to respond to hospital consolidation.[19] In this view, the hospital community has responded to the call for more integrated care by consolidating and acquiring market power and thus health insurers have the need to acquire countervailing power. There is, however, no economic evidence that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits consumers. Professor Thomas Greaney observes that such

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[16] Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation* 2013; 1(3) 16-35.

[17] *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* HEALTH L. HANDBOOK (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 L. & CONTEMP. PROBS. 237 (1988); Federal Trade Comm'n and U.S. Dep't of Justice, *Improving Health Care: A Dose of Competition* (July 2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 L. & CONTEMP. PROBS. 195 (1988); Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012), *available at*: http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care.

[18] Su Liu & Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature* ix (Mathematic Policy Research Ref. No. 6203-042, 2006), *available at*: http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf.

[19] *See* "Health Care Management Professor Mark Pauly PhD Discusses Proposed Health Care Insurance Company Mergers," *available at*: http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/; Greaney, "Examining Implications of Health Insurance Mergers," *available at*: http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/.

matches often end in a handshake and consumers get crushed.[20] The better answer to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that by encouraging entry into hospital markets, hospital markets can be made competitive. We discuss that solution under "Hospital Consolidation," below.

Mergers Resulting in Health Insurer Monopsony Power Could Harm Consumers

We believe that the DOJ, FTC, and state attorneys general should closely scrutinize any health insurer merger where the merged entity would likely be able to lower reimbursement rates for physicians and other providers to anticompetitive levels that would result in a reduction in the quality or quantity of services offered patients. The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the merger would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,[21] and the merger of United Health and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.[22] In a third merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that the merger "would have given Blue Cross Michigan the ability to control physician reimbursement rates in a manner that could harm the quality of healthcare delivered to consumers."[23]

DOJ's monopsony challenges properly reflect the Agency's conclusions that it is a mistake to assume that a health insurer driving down medical fees, in the exercise of monopsony power, is a good thing for consumers. Insurers' interests are not perfectly aligned with those of consumers. First, health insurer monopsonists typically are also monopolists. Therefore, their lower input prices (for physician services) do not necessarily lead to lower consumer output prices (for health insurance premiums).[24] Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of

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[20] Greaney, *supra* note 19.

[21] *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.

[22] *U.S. v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), *available at*: www.usdoj.gov/atr/cases/f213800/213815.htm.

[23] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, *available at*: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

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

nearly 50,000 pages of expert and other commentary,[25] the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted 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.[26]

Indeed, there may be antitrust concerns if a health insurer can lower compensation to physicians even if it cannot raise premiums for patients. Hence 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.[27] For example, compensation below competitive levels hinders physicians' ability to invest in new equipment, technology, training, staff, and other practice infrastructure that could improve the access to, and quality of, patient care. It may also force physicians to spend less time with patients to meet practice expenses.

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care

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[25] *See* background information, including excerpts from the experts, *available at*: *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf.*

[26] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

[27] *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, at 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.

delivery and payment methods, projects shortages in both primary and specialty care.[28] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[29]

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.[30] According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.[31] Furthermore, recent research finds evidence that insurer consolidation leads to the exercise of buyer or monopsony market power in physician markets, resulting in prices paid to physicians that are below competitive levels and thereby reducing the quantity or quality of health care, which in turn harms consumers.[32]

Anticompetitive Effects May be Felt by Consumers and Physicians in The Market for Medicare Advantage

We believe that the DOJ, FTC, and state attorneys general should also examine the proposed megamergers for their potential effects in the markets for Medicare Advantage. In performing this analysis, federal and state regulators should scrutinize the claims of merger proponents that the Medicare Advantage market is not problematic because consumers have the option of enrolling in traditional Medicare. In prior mergers of insurers offering Medicare Advantage plans, the DOJ has determined that Medicare is not an adequate substitute for Medicare Advantage primarily because Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.[33] Moreover, the Agency has found that seniors would not likely switch away from Medicare Advantage plans to traditional Medicare to defeat an anticompetitive Medicare Advantage price increase. These conclusions are bolstered by research to the effect that Medicare is not an equal substitute for Medicare Advantage. The programs constitute separate and distinct product markets, such that the proposed mergers should be

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[28] *See* IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025* (Prepared for the Association of American Medical Colleges, 2015).
[29] *See* Health Resources and Services Administration, "Projecting the Supply and Demand for Primary Care Physicians through 2020 in brief" (November 2013).
[30] Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.
[31] *Id.*
[32] *See* L. Dafny et al. "Paying a Premium on Your Premium?" Consolidation in the US Health Insurance Industry", American Economic Review 2012; 102 (2): 1161-1185.
[33] *See U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008); United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), *available at:* www.justice.gov/atr/cases/f281600/281618.pdf).

evaluated for their effects in the Medicare Advantage market.[34] The closest competition to one Medicare managed care plan is another Medicare managed care plan. Thus, it is the presence of many competing managed care plans that keeps quality competitive.[35]

Moreover, mergers resulting in monopsony power within the Medicare Advantage market would likely be felt most acutely by physicians who specialize in providing services to the elderly. With limited capacity to expand their business to traditional Medicare, these physicians may be especially harmed by the exceptionally high degree of concentration in the Medicare Advantage market, where the lack of competition enables insurers to depress fees paid to physicians for services under Medicare Advantage.

The Record on Merger Enforcement in Health Insurer Markets Should be Improved

Given the troubling absence of competition in health insurance markets, the AMA believes federal and state regulators should redouble their efforts in preventing anticompetitive health insurance mergers. While there have been hundreds of mergers involving health insurers and managed care organizations, the DOJ has never fully litigated a single challenge to a health insurer merger. It has, however, challenged four such mergers and settled them through consent decrees.[36] In a fifth case, the health insurers abandoned their planned merger when DOJ advised them that it would challenge the transaction.[37]

The Likely Inadequacy of the Remedy of Health Insurer Divestitures

A reason for the discussed health insurer merger proposals to receive a heightened level of scrutiny before they take effect is that a post-merger remedy, such as divestiture, could be highly

[34] R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; L.Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

[35] *See U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA business in the Las Vegas area as a precondition to obtaining merger approval); *see also* Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), *available at:* http://content.healthaffairs.org/content/34/1/48.full.pdf.

[36] Humana's acquisition of Arcadian management services in 2012 (Humana/Arcadian); United Health Group's acquisition of Sierra Health in 2008 (United Sierra); United Health Group's acquisition of Pacific Care in 2006 (United/Pacific Care); and Aetna's acquisition of Prudential in 1999 (United/Prudential). Humana/Arcadian and United/Sierra concerned the Medicare Advantage markets, while United/Pacific Care and Aetna/Prudential focused on the commercial health insurance markets. *See U.S. v. Humana*, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), *available at*: www.justice.gov/atr/cases/f281600/281618.pdf); *U.S. v. UnitedHealth Grp., Inc.*, No. 08-cv-00322 (D.D.C. Feb. 25, 2008), *available at:* www.justice.gov/atr/cases/f230400/230447.htm); *U.S. v. UnitedHealth Grp., Inc.*, No. 05-cv-02436 (D.D.C. Dec. 20, 2005) (UnitedHealth Group Complaint), *available at:* www.justice.gov/atr/cases/f213800/213815.htm); *U.S. v. Aetna, Inc.*, No. 99-cv-398-H (N.D. Tex. June 21, 1999), *available at:* www.justice.gov/atr/cases/f2500/2501.htm).

[37] *See* DOJ press release, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans, *available at*: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

disruptive to the marketplace and cause harm to consumers. As such, the remedy of divestiture in a health insurer merger case is problematic. The would-be purchaser of the divested business would need to be able to offer a provider network at a cost and quality comparable to that of the merger parties. Given the barriers to entry to health insurance, such a qualified purchaser, if found, would likely already be a market participant and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

Also troublesome is the apparent absence of a viable divestiture remedy in a national market where five national insurers are at least potentially competing for employer contracts. There are no would-be purchasers with the size and scope of the existing five national insurers that could replace the lost national competition.

HOSPITAL CONSOLIDATION

Anticompetitive Effects in Hospital Services Markets

Many hospital markets are already highly concentrated and noncompetitive.[38] Anticompetitive hospital mergers and acquisitions may further undermine the ability of physicians on behalf of patients to shop for hospitals based upon quality factors, such as the hospital's level of investment in modernizing and maintaining its physical plant and equipment, the quality and experience of the nurses and other professionals who practice there, and the resources it makes available to physicians. Too much consolidation reduces the incentive of hospitals to compete on these factors, allowing the merged hospitals in a concentrated market to provide potentially sub-optimal care for patients.

Anticompetitive Effects of Hospital Horizontal Mergers in the Markets Where Hospitals Acquire Physician Services

A hospital acquiring market power through merger may also substantially lessen the practice options open to physicians such that the hospital obtains market power as an acquirer of physician services (i.e., monopsony power). For example, physicians with established practices and relationships in a local community and unable to "start over" in another community may feel coerced to accept an unfavorable hospital practice affiliation or employment for fear that they will no longer have access to a sufficient number of patients or referrals if they remain independent. Additionally, a hospital's monopsony power in the market for physician employment may enable the hospital to depress the compensation of employed physicians to below competitive levels or to maintain unfavorable physician-patient ratios.[39] Moreover, there

[38] *See* Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[39] Anticompetitive hospital mergers can also harm patient care by driving physician resources away from the affected markets.

is the concern that physicians working for dominant hospitals could experience divided loyalties and may feel that the interests of the hospital may not always be consistent with what they believe is in the best interests of the patient.[40]

Hospital Vertical Consolidation

The AMA closely monitors trends in hospital physician practice acquisition and employment. In June 2015, using our Physician Practice Benchmark Survey (Survey), the AMA published a Policy Research Perspective entitled, "Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership." It found that in 2014, 32.8 percent of physicians worked either directly for a hospital or for a practice that was at least partially owned by a hospital. This percentage represented an increase from 29 percent identified in a 2012 AMA analysis, and 16.3 percent identified in a 2007 AMA study. Nevertheless, the majority (60.7 percent) of physicians still work in small practices with 10 or fewer physicians, and 56.8 percent of physicians work in practices wholly owned by physicians, only a slight decrease from 2012 when 60.1 percent of physicians worked in physician-owned practices.

Assuming the absence of hospital monopsony power, economic theory does not provide clear predictions concerning the positive or negative effects that hospitals' acquisition of physician practices may have on health care competition and consumer welfare. Predictions may be particularly difficult in the context of hospital practice acquisition because of the rapid evolution in health care payment and delivery markets in the U.S. Until we know whether these acquisitions are benign, health policy makers should be supportive of physician-led innovative alternatives for achieving the benefits of coordinated care without a full merger. Taking a similar view is a 2013 Brookings Institution report suggesting that non-merger forms of integration of limited duration, such as contractual joint venture clinical integrations, should be preferred over mergers.[41] Such contractual joint ventures "are easier to modify or undo than provider mergers if they do not work. They may also permit more flexibility in health care organization as further innovations occur in health care delivery."[42]

There is another strong overriding policy reason for encouraging alternatives to integrated delivery systems formed through hospital acquisitions. One of the most important ways to reduce healthcare costs is to prevent the need for hospitalizations through more effective prevention programs, early detection, improved chronic disease management and other proactive measures.[43] These initiatives are achieved primarily or exclusively through the actions of

[40] R. Pear, "Doctors Warned on 'Divided Loyalty,'" *New York Times*, December 26, 2012.
[41] *See* Bending the Curve: Person-Centered Health Care Reform—A Framework for Improving Care and Slowing Health Care Cost Growth (Brookings, April 2013).
[42] *Id.*
[43] CMS has recognized that "the savings cemented by ACOs, in many cases is expected to result from reduced inpatient admissions." 76 Fed. Reg. 19537.

physician practices, not by hospitals themselves. Moreover, to the extent that these initiatives are successful, they will not only reduce the hospitals' revenues, but they may have a negative impact on the hospital's margins, assuming hospital revenues decline more than their costs can be reduced. Thus, where a hospital controls an integrated delivery organization, the hospital may be more likely to resist physician efforts to reduce the need for hospitalizations.

Obtaining Benefits of Coordinated Care Without Full Merger

The movement from fee-for-service to "value-based" reimbursement, and the attendant creation of entities such as ACOs designed to meet the full set of needs of a defined population, has called upon provider communities to coordinate their care.[44] This has reinvigorated interest in integration. Unfortunately, we continue to see barriers to physician participation in APMs, especially for small and specialty practices, and resulting barriers to competition. Participation by these practices is essential because it ensures patient choice, preserves the physician-patient relationship, and provides greater competition in health care markets.

Despite the need for their participation, a recent study by the AMA, in conjunction with the RAND Corporation, found that small practices may face challenges participating in APMs due to the complex infrastructure needed to implement them. Consequently these small practices are affiliating or merging with other practices or becoming aligned or owned by hospitals.[45] Specifically, practice leaders reported that among the most prominent payment model-related reasons for these mergers was the enhancement of practices' ability to make the capital investments required to succeed in certain APMs (especially investments in computers and data infrastructure) and to negotiate contracts with health plans (including which performance measures and targets would be included).

For example, in the aforementioned Comprehensive Care for Joint Replacement Payment Model announced this past summer, CMS is currently proposing a mandatory demonstration project to coordinate care for certain joint replacement procedures.[46] While the AMA strongly supports efforts by CMS to make appropriately structured APMs available to physicians and other providers, we are concerned that aspects of the program, including its mandatory nature, may have negative unintended consequences that undermine its main policy goals, Some physicians, especially those practicing in small offices, lack access to the infrastructure and resources necessary to participate in APMs due to barriers to integration posed by factors such as antitrust

[44] The federal government has set the goal of tying 30 percent of traditional Medicare payments to alternative models by the end of 2016, and 50 percent of payments by the end of 2018. In addition, the aforementioned MACRA legislation of 2015 will further promote APMs by providing five percent bonus payments each year for five years to physicians who participate in models that are accountable for more than nominal financial risk.

[45] The RAND Corporation with Sponsorship by the AMA, *Effects of Health Care Payment Models on Physician Practice in the United States* (March 2015), *available at*: http://www.rand.org/pubs/research_reports/RR869.html.

[46] 80 Fed. Reg. 41197-41316 (July 14, 2015).

and program integrity rules. With alternative routes to clinical integration closed off, small physician practices facing mandatory participation in a CMS program may have no other choice but to be bought out by a hospital, thereby exacerbating the effects of hospital vertical integration.

New Physician-Driven Entry as an Antidote to Hospital Market Concentration

As observed above, many hospital markets are highly concentrated and noncompetitive.[47] Moreover, embedded hospital market concentration is fast becoming an intractable problem for which antitrust provides no remedy.[48] Fortunately, regulators can take steps to encourage new entry.[49] Low-hanging fruit in this area would be removing barriers to health care market entry that the government itself has erected. These include more flexible antitrust enforcement policies to foster physician networks engaged in APMs and the elimination of state certificate of need (CON) laws and the ban placed by the ACA on physician-owned specialty hospitals (POHs). This latter restriction is radically inconsistent with the general thrust of the ACA, which is to encourage competition, such as the creation of health insurance exchanges and the formation of new delivery systems.

Certificate of Need

The AMA, like the FTC and the DOJ, has long advocated for the abolishment of CON. Some progress has been made as 14 states have discontinued their CON programs. Thirty-six states, however, currently maintain some form of CON program. According to the National Conference of State Legislatures, the existing CON programs concentrate activities on outpatient facilities because these tend to be freestanding, physician-owned facilities that constitute an increasing segment of the health care market.[50] Many of these physician-owned facilities are ambulatory surgical centers (ASC) that, as a class of provider, have been found in numerous studies of quality to have complication rates that are low and patient satisfaction that is high.[51] For example, a recent study published in *Health Affairs* concluded that ASC "provide a lower-cost alternative to hospitals as venues for outpatient surgeries."[52] Numerous studies have shown that CON laws have failed to achieve their intended goal of containing costs.[53] Instead, CON has

[47] *See* Gaynor and Town, *supra* note 38.
[48] *See e.g.* Greaney, *supra* note 2 ("Antitrust does not break up legally acquired monopolies or oligopolies.").
[49] *Id.*
[50] *See* National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (July 2014), *available at*: http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.
[51] *See* L. Casalino et al., "Focused Factories? Physician-owned Specialty Facilities", *Health Affairs* (Millwood) 2003; 22(6): 56-67.
[52] *See* Munnich and Parente, "Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up," *Health Affairs* (Millwood) 2014, 33(5): 764-769.
[53] *See* Michael A. Morissey, *State Health Care Reform: Protecting the Provider*, in American Health Care: Government, Market Processes, and the Public Interest, at 243-66 (Roger D. Feldman ed., Transaction Publishers 2000).

taken on particular importance as a way to claim territory and to restrict the entry of new competitors.[54] It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities, CON laws have weakened the markets' ability to contain health care costs, undercut consumer choice, and stifled innovation. Thus, the AMA urges the FTC and the DOJ to redouble their efforts in advocating for the repeal of CON laws.

Physician-Owned Hospitals

The Medicare Payment Advisory Commission (MedPAC) has observed that "…some physicians want to expand the range of cases seen in ASCs to include patients who might require more monitoring and an overnight stay. Doing so requires conversion of the ASC to a hospital."[55] This was possible prior to the enactment of the ACA when there were approximately 265 POHs concentrated in states that do not have CON.[56] At that time, physicians enjoyed a "whole hospital exception" to the Stark Law, meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital.

However, provisions within section 6001 of the ACA "essentially create a federal certificate of need requirement" for POH.[57] First, section 6001 eliminates the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, the POH cannot expand its treatment capacity unless certain restrictive exceptions can be met. Thus, as Professor Greaney observes, "the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."[58]

Quality and Cost Record of Physician-Owned Hospitals

The lost source of competition is especially missed because POHs have developed an enviable track record for high quality and low cost care. A CMS study found that measures of quality at physician-owned cardiac hospitals are generally at least as good, and in some cases better, than at local community hospitals. According to CMS, specialty hospitals offer very high patient

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[54] *Id.;* Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics,* Research Brief 4, National Institute for Health Care Reform (May 2011).
[55] Medicare Payment Advisory Commission, Report to the Congress; Physician-Owned Specialty Hospitals, (March 2005) at 8, available at: http://medpac.gov/documents/reports/Mar05_Spec1.lospitals.
[56] H.R. REP. NO. 111-443, at 4 (2010); Casalino, *supra* note 51, at 56-67.
[57] 42 USC 1395nn; Joshua Perry, *An Obituary for Physician-Owned Specialty Hospitals*; 23(2) HEALTH LAWYER 24 (American Bar Association, December 2010).
[58] Greaney, *supra* note 2, at 841.

satisfaction and high quality of care.[59] More recently, the comparative efficiencies of POHs are shown in the results of CMS' Hospital Value-Based Purchasing Program. Nine of the top 10 performing U.S. hospitals listed in late 2012 by CMS were POHs. Of the 238 POHs in the U.S., 48 were ranked in the top 100.[60]

There are additional studies showing that many of the POHs achieve greater patient satisfaction, reduce costs, and improve infection rates.[61] Professor Ashley Swanson's research finds that "treatment at a physician-owned hospital can lead to substantial improvements in mortality risks for cardiac patients."[62] She concludes that "the results suggest that banning of further physician ownership as part of the ACA may have detrimental effects on patient health."[63]

Whereas opponents of POHs misleadingly attribute their success to so-called "cherry-picking" of patients who are less severely ill and less costly to treat, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[64] CMS' analysis found no difference in referral patterns to community hospitals between physician owners and non-owners. An independent study released just last week and published in the *British Medical Journal* concluded that POHs are not cherry-picking patients or self-selecting more lucrative cases.[65] The advantages of POHs to patients are real and substantial, especially when new entry into many hospital markets is critical to their competitiveness and when alternative delivery and payment models requiring physicians to control hospital costs are the order of the day. Therefore, we strongly recommend that the Congress act on the need to remove restrictions on POHs in order to improve competition.

The POH Relative Ease of Market Entry and Competitive Response of Established Hospitals

New competition is vital to markets that are dominated by a single powerful hospital or system, and POHs have advantages over facilities that are controlled by non-physician owners or investors. New facilities may be reluctant to enter such markets because a first step in successful entry is physician recruitment, and it may be difficult to lure physicians away from systems

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[59] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (CMS Report), *available at*: http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.
[60] *See* American Medical News (April 29, 2013).
[61] *See e.g.* Casalino, *supra* note 51, at 56-67; Ashley Swanson PhD Assistant Professor, The Wharton School, University of Pennsylvania and Faculty Research Fellow, National Bureau of Economics, *Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care,* December 18, 2013 (Working paper), *available at*: https://www.econ.berkeley.edu/sites/default/files/swanson_poh_curr%20(1).pdf
[62] *Id.*
[63] *Id.*
[64] CMS Report, *supra* note 59, at 26.
[65] Jordan Rau, "Doctor-Owned Hospitals are Not Cherry-Picking Patients, Study Finds," *Kaiser Health News*, September 3, 2015, available at: http://khn.org/news/doctor-owned-hospitals-are-not-cherry-picking-patients-study-finds/.

where so many physicians are employed. Physician owners may have an advantage in building a medical staff de novo, and could therefore successfully enter where others dare not. Lifting the ban on POHs could raise the performance of the entire hospital market. The market entry of POHs would induce incumbent community hospitals to attempt to "meet the competition" in inpatient services by extending patient hours, improving scheduling, and upgrading equipment.[66]

Competition plays a major role in enabling consumers to access the high quality care they deserve at a reasonable cost. The AMA applauds the Subcommittee's efforts to examine health care industry consolidation and enhance access, choice, and quality through improved competition. We appreciate the opportunity to provide our comments on this important topic, and we look forward to working with the Subcommittee and Congress on achieving high quality, cost-effective care for all Americans.

[66] Medicare Payment Advisory Commission, Report to the Congress: Physician-Owned Specialty Hospitals (March 2005) at 10, *available at*: http://medpac.gov/documents/reports/Mar05_SpecHospitals.

Mr. MARINO. Thank you, Dr. McAneny.
Mr. Durham?

TESTIMONY OF DANIEL T. DURHAM, EXECUTIVE VICE PRESIDENT, STRATEGIC INITIATIVES, AMERICA'S HEALTH INSURANCE PLANS

Mr. DURHAM. Good morning, Subcommittee Chairman Marino, Chairman Goodlatte, Ranking Member Johnson, and Members of the Subcommittee. I am Dan Durham, Executive Vice President at America's Health Insurance Plans, and I appreciate this opportunity to testify on issues regarding competition in the health care system.

A competitive health care system is the best way to achieve innovative, high-quality, affordable health care. Competition among health plans occurs at the local level, and the diversity of AHIP's membership, which includes local, regional, and national plans, reflects the many choices available to consumers.

Innovation in payment and delivery has resulted in a broad range of options available in the marketplace as health plans continually work, in collaboration with providers, to improve the value of their products for consumers. Our written testimony highlights initiatives that our members have pioneered to promote quality and affordability, as well as consumer tools that promote patient-centered care.

Regarding competition in the marketplace, the Department of Health and Human Services reports that an average of 40 plan options are available per county in 2015. That is up from 30 last year. And McKinsey reports a 26 percent increase in the number of issuers competing on exchanges. Competition within local markets is evolving, with a variety of high-value products, from patient-centered medical homes to bundled payments to accountable care models. The range of collaborative products that drive value is vast, and health plans tailor these products to help meet the specific needs of local patient populations.

As has been reported, there is merger activity in the health insurance industry. While I can't speak to the potential outcomes of these reviews, it is important to understand the broad framework that the antitrust agencies use to evaluate whether a particular transaction is procompetitive or anticompetitive, and the evolving nature of the market for health coverage.

Assessing the impact of proposed mergers should start with a clear understanding that many mergers and acquisitions are beneficial to consumers. They facilitate new, high-value products and efficiencies that reduce cost. The Department of Justice has indicated, "The primary benefit of mergers to the economy is their potential to generate significant efficiencies, and thus enhance the merged firm's ability and incentives to compete, which may result in lower prices, improved quality, enhanced service, or new products." The DOJ, along with 50 state attorneys general and insurance commissioners play an important role in reviewing proposed mergers and determining their potential impacts. This includes a thorough evaluation of a large body of data and other evidence to determine whether a merger would harm consumers by adversely

impacting competition in specific products and specific geographic areas.

Notably, there is no single national market for health coverage. Health plans negotiate with providers in local markets and offer particular types of products that differ widely from one another. The agencies also consider the nature of the market itself and whether it is undergoing changes that are relevant to its analysis. For example, the highly regulated nature of health insurance markets is relevant to an analysis of the potential competitive effects of transactions. This highly regulated market we face distinguishes health insurance from other less regulated markets.

The bottom line is that consolidation should be looked at on a case-by-case basis and it is problematic only when a transaction leads to anticompetitive effects such as an increase in cost resulting from harmful consolidation in provider markets.

There is substantial evidence in peer-reviewed research that shows a significant share of health care cost increases are driven by dominant providers charging higher prices. The Robert Wood Johnson Foundation study found that increases in hospital market concentration lead to increases in the price of hospital care, and that when hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent. This study further cautions that physician-hospital consolidation has not led to either improved quality or reduced costs. Other studies that we have detailed in our written testimony show that anticompetitive consolidation in provider markets is resulting in higher health care costs for consumers and employers and government programs.

Thank you again for this opportunity to testify. AHIP and our members look forward to continuing to work with the Subcommittee and other stakeholders to improve patient access to high-quality, affordable health care.

[The prepared statement of Mr. Durham follows:]

Competition in the Health Care Marketplace

by

Daniel T. Durham
Executive Vice President, Strategic Initiatives
America's Health Insurance Plans

for the
House Judiciary Committee
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

September 10, 2015

I. Introduction

Chairman Marino, Ranking Member Johnson, and members of the subcommittee, I am Dan Durham, Executive Vice President for Strategic Initiatives at America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. AHIP's members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market and the Exchanges, and public programs such as Medicare and Medicaid through localized networks that provide access to physicians and health care facilities in consumers' communities. Our members essentially act as the negotiators, on behalf of consumers, with health care providers, such as hospitals and pharmaceutical companies, to seek high quality services at the most competitive prices possible. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

Health plans are committed to ensuring that their enrollees receive high quality health care at competitive prices. As part of those efforts, health plans increasingly work with hospitals and providers to improve care coordination and deliver better value for patients. By advancing new and emerging models of payment and care delivery, health plans are taking a leading role in moving away from the antiquated fee-for-service model to a health system that promotes higher quality and more affordable care for consumers.

We appreciate this opportunity to testify on issues surrounding competition in the U.S. health care system. These issues have far-reaching implications for the cost of health care, quality improvement, consumer choice, and innovative approaches to the delivery of care. We applaud the subcommittee for holding this hearing to call attention to these important issues.

Our testimony today focuses on the following topics:

- The importance of continuing to ensure vigorous competition in local markets throughout the health care system;

- The fact that consolidation of some companies can have strong pro-competitive effects and is only harmful if anticompetitive effects can be demonstrated;

- The harmful impact of anticompetitive consolidation among hospitals and other health care providers; and

- The harmful impact of monopoly pricing in the pharmaceutical industry.

II. The Importance of Ensuring Vigorous Competition in the U.S. Health Care System

A competitive health care system is the best way to achieve innovative, high quality, affordable health care for all Americans. Vigorous competition in the marketplace creates incentives for all stakeholders to increase efficiency and hold down costs for consumers. Health plans operate in competitive markets and the Exchanges have demonstrated impressive growth in competitive options already. It is important to recognize that this competition among health plans occurs at the local level in specific geographic areas, and that new coverage options – including those resulting from collaboration between plans and providers – are emerging and evolving on an ongoing basis. The diversity of AHIP's membership – which includes local, regional, and national insurers – reflects the many choices consumers have when shopping for health insurance coverage in their area.

The Department of Health and Human Services (HHS) has released a research brief[1] that highlights the broad range of choices that are available to consumers through the Exchanges established by the Affordable Care Act (ACA). The HHS research brief, focusing on 35 states, indicates that an average of 40 plan options are available per county in 2015 – up from an average of 30 plan options per county last year. The growth in choices and competition in the ACA Exchanges also is demonstrated in an analysis[2] by McKinsey & Company, which focused on 41 states and found that the number of insurers competing in the Exchanges increased by 26 percent between 2014 and 2015.

Similarly, for seniors and individuals with disabilities, a wide range of health plan choices are available in the Medicare Advantage (MA) program. According to an analysis[3] by the Kaiser Family Foundation, Medicare beneficiaries were able to choose from an average of 18 MA plan options when making their enrollment decisions for the 2015 benefit year. In addition,

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[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace, January 8, 2015
[2] McKinsey & Company, 2015 OEP: Emerging trends in the individual exchanges, November 2014
[3] Kaiser Family Foundation, Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes, December 10, 2014

beneficiaries were able to choose from an average of 30 stand-alone prescription drug plans (PDPs) under the Medicare Part D prescription drug program.[4]

Survey findings consistently show that a large majority of consumers are satisfied with their health plans. The Commonwealth Fund Affordable Care Act Tracking Survey,[5] conducted in March-May 2015, found that 86 percent of enrollees in Exchange plans and newly enrolled Medicaid beneficiaries are satisfied with their health insurance. Similarly, a national survey of Medicare Advantage enrollees found that 90 percent of respondents were satisfied with their coverage.[6]

In the health insurance marketplace, competition is helping to drive innovative programs as health plans continually work – in collaboration with providers and other partners – to make their products more appealing to consumers and employers based on both quality improvements and cost savings. Our members have demonstrated strong leadership in developing and implementing initiatives in the areas discussed below.

Health plans are promoting quality and affordability by implementing a variety of provider-based strategies including:

- Rewarding quality and promoting evidence-based health care through payment and care delivery reforms, such as bundled payment and accountable care contracts, as part of an industry-wide effort to advance alternative payment models that align with, and laid the groundwork for, the new Medicare physician payment reform law;

- Partnering with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;

- Collaborating with physicians in their efforts at practice transformation, through activities such as direct clinical support and provision of meaningful and actionable data, to drive quality improvements, improved outcomes, and cost savings; and

[4] Kaiser Family Foundation. Issue Brief: Medicare Part D: A First Look at Plan Offerings in 2015, October 2014
[5] Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015
[6] North Star Opinion Research, National Survey Of Seniors Regarding Medicare Advantage Plans, February 6-11, 2013

- Improving the flow of information between clinicians and plans by simplifying administrative processes and data exchange to improve care.

Similarly, health plans are driving value through programs and tools that promote patient-centered care and help consumers make value-based decisions, including:

- Offering a wide variety of provider networks for consumers and employers – integrated care delivery products, high performance networks based on cost and quality measures including health outcomes, tiered networks, and networks that offer the broadest possible selection of providers (In the 2015 Exchange market, 90 percent of consumers had access to both narrowed and broad-network plans, up from 86 percent in 2014);[7]

- Implementing standardized performance measures to provide consumers with better information about quality and costs to help them make value-based decisions about their medical treatments and how their health care dollars are spent;

- Providing disease management services to enrollees who stand to benefit the most from early treatment and care interventions;

- Offering personalized risk assessments, wellness programs, and consumer tools that provide information on the cost of health care services;[8] and

- Encouraging electronic prescribing and consumer safety alerts.

These initiatives are being pioneered across the nation by health plans of all sizes, including local, regional, and nationwide insurers.

Plan-Specific Examples:

Independence Blue Cross in Pennsylvania has implemented patient-centered medical homes to improve patient health and lower costs through a team-oriented approach to primary care. Key components of this initiative include an emphasis on coordinated care among all health care professionals, electronic health records to better track care, open scheduling to allow for more

[7] McKinsey Center for U.S. Health System Reform, Hospital networks: Evolution of the configurations on the 2015 exchanges, April 2015
[8] AHIP Issue Brief, Health Plan Tools Empowering Consumers with Provider Price Information, August 2015

flexibility in seeing patients when they need care, and more interaction with the physician and staff between appointments to ensure that scheduled tests and consultations occur. Under this program, the transition to a medical home was associated with a statistically significant 5 to 8 percent reduction in utilization of Emergency Departments (ED) for patients with chronic illnesses who have one or more ED visits in any given year. The reduction in ED visits was most evident among patients with diabetes, who experienced a 9.5 to 12 percent reduction.[9,10]

Blue Shield of California is collaborating with Dignity Health (formerly Catholic Healthcare West) and Hill Physicians on an accountable care model for members of the California Public Employees' Retirement System (CalPERS) in the greater Sacramento region. Each organization shares clinical and case management information to tightly coordinate care. By sharing data, the three organizations have been able to identify areas where costs are unduly high and implement solutions to bring those costs down. Results for 2010 included: a 15 percent reduction in inpatient readmissions; a 15 percent decrease in inpatient days; a 50 percent decrease in inpatient stays of 20 or more days; a half-day reduction in average patient length of stay; and $15.5 million in savings.[11] Over three years, this initiative reduced premiums for CalPERS beneficiaries by $59 million, or $480 per member per year.[12]

Blue Cross Blue Shield of Michigan has implemented a Cardiovascular Consortium to facilitate better collaboration among health care providers to address the goals of: (1) improving care for patients with coronary disease undergoing angioplasty; and (2) decreasing complications and improving medical therapy for patients with severe peripheral arterial disease undergoing peripheral vascular intervention and open vascular surgeries. The first initiative achieved, from 2002 to 2011, a 20 percent reduction in hospital deaths, a 92 percent reduction in emergent coronary artery bypass grafts, and a 40 percent reduction in vascular complications. The second initiative achieved, from 2007 to 2011, a 25 percent reduction in the death rate, a 50 percent reduction in vascular complications, and a 22 percent reduction in the need for blood transfusions.

Indeed, many of the initiatives noted above involve health plans partnering with providers in a manner that supports a comprehensive approach to improving quality and affordability. Health

[9] Health Services Research, Do Patient-Centered Medical Homes Reduce Emergency Department Visits?, August 12, 2014
[10] AJMC Managed Markets Network, Medical Homes and Cost and Utilization Among High-Risk Patients, March 24, 2014
[11] Fact Sheet: Blue Shield of California and Accountable Care Organizations (ACOs)
[12] The Commonwealth Fund, Hill Physicians Medical Group: A Market-Driven Approach to Accountable Care for Commercially Insured Patients, October 2014

plans have been leaders in the adoption of patient-centered medical homes, which replace episodic care with a sustained relationship between patient and physician. Similarly, health plans have been strong partners in many accountable care contracts, with promising early results in reducing preventable readmissions and total inpatient hospital days.[13] The range of such efforts is vast, beginning with the point of contact with the patient and extending all the way to partnerships between plans and providers.

In this dynamic health care market, health plans are focused on tailoring these collaborations to their enrollees' health needs so that care is truly patient-centered. By supporting these efforts, policymakers will help quality improvement initiatives flourish in a variety of forms, with the benefits flowing to consumers and their employers as plans and providers work together to reduce costs and improve quality.

III. Consolidation of Companies Can be Pro-Competitive

The discussion of consolidation in the health care sector needs to begin with a clear understanding that many mergers and acquisitions are beneficial to consumers. They can be transformative, facilitate new and better products and services, and lead to efficiencies that reduce costs. The Federal Trade Commission (FTC) and the Department of Justice (DOJ), which have authority to enforce federal antitrust laws, have indicated that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products."[14] Consolidation should be looked at on a case by case basis and is then problematic only when a transaction leads to anticompetitive effects, generally an increase in costs. The FTC and the DOJ, along with the 50 states Attorneys General, play an important role in reviewing proposed mergers and determining their potential impacts.

As has been reported, there is merger activity in the health insurance industry. The DOJ's review of these proposed mergers will be, as with any such merger analysis conducted by the agencies, very fact intensive. While I cannot speak to the potential outcomes of these reviews, it is important to understand the broad framework that the antitrust agencies use to evaluate

[13] *Health Affairs*, Early Lessons From Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers, Aparna Higgins, et al. (commissioned by AHIP), September 2011
[14] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2010

whether a particular transaction is pro-competitive or anticompetitive, and the evolving nature of the market for health coverage.

As the agencies review a proposed merger, they carefully evaluate a large body of data and other evidence to determine whether a merger would harm consumers by adversely impacting competition in specific products or specific geographic markets. It is important to note that there is no single national market for health coverage. Health insurance purchasers buy coverage in local markets, and for particular types of products, that differ widely from one another. Even the large national employers who buy coverage for employees across the country often offer their employees a range of choices from local, regional, and national plans (much as the federal government does for its employees).

The total size of the merging entities alone is not a determining factor. Rather, the agencies look at potential anticompetitive effects in particular markets regardless of size. This is true for mergers involving hospitals, insurers, and indeed any entity in any industry.

The agencies also consider the nature of the market itself and whether it is undergoing changes that are relevant to their analysis of the transaction. For example, the highly regulated nature of health insurance markets is relevant to an analysis of the potential competitive effects of transactions. Medicare Advantage plans are subject to extensive federal regulation and Medicaid plans are subject to extensive federal and state regulation. Commercial health insurance plans are highly regulated at both the national level (e.g., medical loss ratio requirements) and the local level (e.g., rate filing and rate review), with the U.S. Department of Health and Human Services and other government agencies exercising oversight over such entities. Such regulation is relevant to the analysis of health insurance mergers and distinguishes health insurance markets from many other, less regulated markets.

Another relevant factor to such review is the nature of the markets themselves. Health insurance markets are in a highly dynamic period and this change is relevant to the analysis of the transactions as well. Competition within local markets is evolving with a variety of entities entering health insurance markets and expanding from one product area into another (e.g., Medicaid plans expanding into commercial markets through Exchange offerings).

Additionally, any analysis of mergers must consider the potential pro-competitive effects that can be generated. In the context of health care, this might include a circumstance when an insurance entity with strength in one particular area is able to offer a better product because it is

joined with an entity that offers complementary strengths. For example, a merger might join an entity with a strong track record of managing chronic conditions in the Medicare Advantage program with another entity that has strengths in meeting the health care needs of beneficiaries who are financially vulnerable through its Medicaid products. The combined entity may be able to leverage these complementary strengths to benefit all of its members. Further, the entity may be able to offer such combined competencies in innovative products on the growing Exchange markets.

In some instances, a merger may help facilitate investments in, and the implementation of, payment and delivery system reforms and streamlined quality measures, all of which support the broader use of value-based initiatives that ultimately benefit consumers.

Other important considerations include the expectation that, following a merger, economies of scale will allow fixed costs to be spread across a larger customer base and that unit costs per customer for medical care and pharmaceuticals will be lower for the merged entity, compared to what they would have been for the original two entities.

IV. The Harmful Impact of Anticompetitive Consolidation Among Hospitals and Other Health Care Providers

Leading up to the passage and implementation of the ACA, our members repeatedly emphasized that affordability of care must be a central objective of health reform. Halting harmful and anti-competitive consolidation that results in higher health care costs in provider markets is an important part of achieving this goal.

Provider-related costs are a significant portion of total medical costs, and the growth in such costs has had a critical, and detrimental, effect on consumers. Consumers benefit when health care providers compete to offer them lower costs, higher quality services, and innovative approaches to delivering care. There are situations in which provider consolidation does not impede these benefits or may even enhance them. In other situations, however, consolidation diminishes competition among providers and leaves consumers with higher costs, diminished quality, and a reduced prospect of innovation or improvement.

The federal antitrust agencies have selectively and carefully challenged mergers of hospitals and provider systems that hold a significant prospect of causing such harm to consumers. While such

challenges represent a relatively small percentage of the total number of hospital mergers, they are of great importance to consumers. Not only do such challenges, and the investigations that preceded them, prevent harm in specific markets, they also deter other anticompetitive transactions by signaling to market participants that anticompetitive transactions will be challenged.

A recent analysis[15] by Kaufman, Hall & Associates found that hospital mergers and acquisitions increased 44 percent between 2010 and 2014, with a total of 442 transactions occurring during this time frame. Moreover, an analysis of provider consolidation by Bates White Economic Consulting[16] found that hospital ownership in 2009 was "highly concentrated" in more than 80 percent of the 335 areas studied. The current wave of provider mergers and the general lack of competitive entry suggests that concentration levels have increased each year since that 2009 study.

A new AHIP data brief[17] highlights research showing a statistically significant positive correlation between increases in health insurance premiums and the degree of hospital concentration in Exchange markets in three states. The findings of this research, based on an analysis of monthly premium data from October 2014, demonstrate that:

- In Georgia, insurance premiums were 35 percent to 52 percent higher in highly consolidated hospital markets compared to premiums for plans offered to residents in markets having less provider consolidation.

- In Missouri, people living in highly consolidated hospital markets paid 31 percent to 46 percent more than those living in areas of the state with greater levels of hospital competition.

- In Ohio, premiums were 9 percent to 13 percent higher in the least competitive hospital markets compared to premiums in more competitive markets.

Our data brief also highlights research from other studies showing, for example, that: (1) physician prices increased, on average, by 14 percent for medical groups acquired by hospital

[15] Kaufman, Hall & Associates, LLC, Number of Hospital Transactions Remains High in 2014, February 9, 2015
[16] Bates White Economic Consulting, Cory Capps, PhD, David Dranove, PhD, Market concentration of hospitals (commissioned by AHIP), June 2011
[17] AHIP Data Brief, Impact of Hospital Consolidation on Health Insurance Premiums, June 2015

systems; (2) hospital mergers in already concentrated markets could result in hospital price increases of as much as 20 percent, without any corresponding improvement in the quality of care; and (3) local hospital ownership and multi-hospital health system ownership of provider groups resulted in per patient expenditures that were 10 percent to 20 percent higher than for patients seen at independently owned groups.

The findings of our data brief are reinforced by numerous other research studies which demonstrate that anticompetitive consolidation in provider markets is resulting in higher health care costs for consumers and employers:

- A January 2015 study,[18] commissioned by AHIP and published by the *Antitrust Health Care Chronicle*, examined the impact of hospital concentration on premiums in California and provides clear evidence that consumers living in regions with many hospital competitors have substantially lower premiums compared to those in regions with highly consolidated hospital markets. This analysis found that more competitive hospital markets had implied premium reductions of more than 8 percent, translating into savings of more than $20 a month for consumers in markets with less hospital concentration.

- A June 2012 study published by the Robert Wood Johnson Foundation (RWJF)[19] found that "increases in hospital market concentration lead to increases in the price of hospital care," and that "when hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent." This study further cautions that "physician-hospital consolidation has not led to either improved quality or reduced costs" and, additionally, points out that consolidation "is often motivated by a desire to enhance bargaining power by reducing competition." An earlier RWJF research project,[20] focusing on hospital consolidation in the 1990s, stated: "Studies that examine consolidation among hospitals that are geographically close to one another consistently find that consolidation leads to price increases of 40 percent or more."

[18] Bates White Economic Consulting, ACA Exchange Premiums and Hospital Concentration in California, January 2015
[19] Martin Gaynor, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, The impact of hospital consolidation–Update, June 2012
[20] William B. Vogt, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, How has hospital consolidation affected the price and quality of health care?, February 2006

- An article published in June 2011 by the *American Journal of Managed Care*[21] found that "hospitals in concentrated markets were able to charge higher prices to commercial insurers than otherwise-similar hospitals in competitive markets."

- An issue brief published in July 2011 by the National Institute for Health Care Management Foundation[22] found that one of the factors contributing to higher prices is "ongoing provider consolidation and enhanced negotiating strength vis-à-vis insurers, resulting in an ability to extract higher payment rates from insurers."

- A 2013 report by the Massachusetts Center for Health Information and Analysis[23] included a discussion about the impact of provider consolidation, noting that the highest priced 25 percent of providers in Massachusetts received over 50 percent of commercial payments made to acute hospitals and physician groups in 2012. A *Boston Globe* article[24] pointed out that the report's findings show that as hospitals and provider groups consolidate, "larger groups often have the leverage to demand higher prices from insurers."

- A September 2013 research brief by the Center for Studying Health System Change[25] reported that "it is clear that provider market power is key in price negotiations and that certain hospitals and physician groups, known as 'must-haves,' can extract prices much higher than nearby competitors." This study also concludes that "increases in provider prices explain most if not all of the increase in premiums" in recent years.

V. The Harmful Impact of Monopoly Pricing in the Pharmaceutical Industry

The pharmaceutical industry is another area where lack of competition has resulted in monopoly pricing – leading to exorbitant costs for consumers. This problem is particularly evident with high-priced specialty drugs. While innovations and breakthroughs in the pharmaceutical field are leading to promising new treatments for serious and life-threatening diseases, the costs associated with these drugs are a source of major concern.

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[21] *American Journal of Managed Care*, Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology, James C. Robinson, PhD, June 24, 2011
[22] National Institute for Health Care Management Foundation, Understanding U.S. Health Care Spending, July 2011
[23] Massachusetts Center for Health Information and Analysis, 2013 Annual Report on the Massachusetts Health Care Market, August 2013
[24] *The Boston Globe*, Partners hospitals, doctors top health-payment list, August 14, 2013
[25] Center for Studying Health System Change, High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power, September 2013

One notable case study involves Sovaldi and Harvoni, two specialty drugs sold by the same manufacturer that have been approved by the Food and Drug Administration (FDA) for treating patients with the Hepatitis C virus. Both of these drugs have price tags of $1,000 or more per pill. Together, they generated a combined total of $4.55 billion in worldwide sales in the first quarter of 2015.[26]

The high cost of these drugs is placing a heavy burden on public programs. In 2014, Medicare spent a combined total of $4.5 billion on Sovaldi, Harvoni, and Olysio (which is often taken in conjunction with Sovaldi) to treat patients who have Hepatitis C.[27] This represents a 15-fold increase relative to the amount Medicare spent on the previous generation of Hepatitis C drugs in 2013. This dramatic increase in costs has significant implications for the long-term financial stability of Medicare. The 2015 annual report[28] of the Medicare Board of Trustees cautioned that "a continuing increase in the use and price of specialty drugs" is a key factor behind the trustees' projection that the growth rate in per capita drug costs will exceed the growth rate of other categories of medical spending in the future. Other public programs – including Medicaid, the Department of Veterans Affairs (VA) health care system, and the Federal Employees Health Benefits Program – also are impacted by these high costs. Additional specialty drugs in the pipeline, including recently approved PCSK9 inhibitors for managing high cholesterol (at an annual cost[29] of $7,000 to $12,000), are poised to have a similar impact on future costs in public programs and in the private marketplace.

Sovaldi originally was researched and developed by Pharmasset, which was planning to market the drug at a cost of $36,000 per treatment course.[30] However, after Pharmasset was purchased by Gilead Sciences, Sovaldi was launched with a price of $84,000 per treatment course – more than double the price envisioned by the developer of the drug. This clear example of monopoly pricing raises serious questions about whether the manufacturer is abusing consumers. In addition, consolidation among drug manufacturers, as well as practices such as pay-for-delay and product hopping, has led to price increases, delays in the availability of generic drugs, and drug shortages.

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[26] *New York Times*, Gilead Hepatitis Drugs Brought In $4.55 Billion in First Quarter, April 30, 2015
[27] *ProPublica*, The Cost of a Cure: Medicare Spent $4.5 Billion on New Hepatitis C Drugs Last Year, March 29, 2015
[28] 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 22, 2015
[29] *Health Affairs*, In The Debate About Cost And Efficacy, PCSK9 Inhibitors May Be The Biggest Challenge Yet, William Shran, Alan Lotvin, Surya Singh, and Troyen Brennan, February 17, 2015
[30] *The Fiscal Times*, The $1,000 Pill That Could Cripple the VA's Budget, Erik Pianin, October 8, 2014

A recently updated AHIP issue brief[31] focuses on the challenges posed by high-priced specialty drugs. Our brief explains that brand-name biologics have a 12-year exclusivity period following FDA approval, and that this government-approved monopoly "removes the economic benefits of price competition, resulting in higher prices relative to what they would be in a perfectly competitive market." Our brief also cites data showing that specialty drugs accounted for only 1 percent of prescriptions in 2014, but 32 percent of all prescription drug spending, and that specialty drug spending is projected to increase by 16 percent annually for the 2015-2018 period, with total spending projected to reach $235 billion by 2018.

VI. Conclusion

Thank you for holding this hearing and for considering our perspectives on these important issues. We appreciate this opportunity to testify about competition in the health care marketplace. We look forward to continuing to work with the subcommittee and other stakeholders to further our shared goal of expanding patient access to high quality, affordable health care.

[31] AHIP Issue Brief, Specialty Drugs—Issues and Challenges, July 2015

Mr. MARINO. Thank you, Mr. Durham.
Dr. Gottlieb?

TESTIMONY OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

Dr. GOTTLIEB. Thank you, Mr. Chairman and Mr. Ranking Member, for the opportunity to testify. My name is Scott Gottlieb. I am a physician and Resident Fellow at the American Enterprise Institute.

The health care sector is undergoing a secular consolidation as payers and providers assume an historic level of acquisition and mergers. These trends were underway prior to implementation of the Affordable Care Act, but there is no question that the ACA hastened them.

The consolidation of physicians at the local level should be a particular concern. In the end, most health care is local. Once an institution has monopolized the providers in its market, it renders market-based reforms hard to achieve and reduces the ability of competition to be used as a tool for improving quality and reducing costs.

More importantly, the new arrangements that are being forged, where doctors become part of large delivery systems, usually with a hospital at its hub, reduces productivity. Compelling economies of scale are not apparent in a physician practice marketplace. This has been borne out by many studies that examine the question, some of which I review in my written statement for this hearing. There is a lot of evidence that as doctors transition to becoming salaried employees of hospitals and health systems, their individual productivity in terms of metrics such as volume and intensity of care delivered also generally declines.

Looking at this in view of our broader fiscal challenges when it comes to health care, the only way that we are going to solve some of the challenges facing the entitlement programs like Medicare is to get more health care for every dollar of GDP that we spend on it. To these ends, the last thing we ought to be doing is adopting structures that reduce productivity.

I know there will be some discussion today of new technology, and particularly drugs, as factors driving increases in the cost of medical care, and I want to just comment briefly on that. However one interprets the data on drug costs, it is widely agreed that many new technologies improve productivity by improving outcomes or obviating costly alternatives.

Take oncology care. Although very costly, total spending on oncology care as a percentage of our $2.7 trillion national health care budget has been constant over the last 20 years. It is just less than 5 percent of total health care spending. It comes out to about .8 percent of GDP. But the mix of expenditure has changed dramatically over time. Far less money is being spent on services like hospitalizations and far more on outpatient medicines. Cancer treatments that used to make patients very sick and require costly hospitalizations have been replaced with targeted drugs that can allow patients to be treated at home.

So the proportion of spending on inpatient care admissions fell from 64 percent of total cancer spending in 1987 to 27 percent by

2005, according to studies. Here is what happened. Transferring cancer care to the outpatient setting produced substantial savings. It is cheaper to deliver care outside the hospital. This is how technology improves productivity and lowers costs, which brings me back to the consolidation underway in the market for health care services.

This consolidation not only reduces productivity and in turn increases costs, it also reduces patient access. This is especially troubling when it comes to rural markets where there is a lower density of doctors and patients can find it harder to get care at a site near their homes. It is important to remember that the scope of the consolidation that we are seeing in health care is not a response to market factors. Rather, it is a deliberate function of policy choices. The ACA envisions doctors practicing in large integrated health systems, often with a hospital at its hub. The idea is that these newly consolidated entities will be big enough to take capitated risk and invest in the kinds of technologies that it is believed will lead to better coordination in medical care. The ACA's mix of policies seeks to hasten these outcomes.

The relationships that doctor practices are forging with their acquiring entities are far stickier than past arrangements. Moreover, for doctors, the opportunity to unwind these business engagements and go back to their old configurations are much more narrow. The economics behind these arrangements also raises some more fundamental questions. For one thing, these constructs were, in part, a response to criticism of a fee-for-service approach to payment, which is widely presumed to give doctors a financial incentive to prescribe more care. As the analysis commonly goes, under a fee-for-service arrangement, doctors are paid more when they do more things and not necessarily when they improve outcomes. But in reaction to these concerns, have we merely traded one flawed set of financial incentives for another? After all, if the financial incentives work in one direction, they have to work in the opposite direction. If doctors will prescribe too much care when they are paid to do more, as critics of the fee-for-service medicine system maintain, won't these same inducements work in reverse? Won't doctors prescribe too little care when they are paid to do less?

This also raises another key question, and this one is clinical. Are patients better off on the margin when they are prescribed a little more care than they need or a little less? The body of literature doesn't fully resolve this question.

Since all health care is local, and the lack of competition will soon make it much harder to implement market-based reforms in health care, the resulting monopolies will make more regulation the most obvious solution to the inevitable cost and quality problems. To change these outcomes, I believe that Congress needs to reform the ACA to remove the pervasive biases in the ACA that favor health system ownership of medical practices. At a time when the urge to merge doctors into health systems and turn physicians into salaried roles, there is a private market counter-effort to create new models that have physicians practicing in smaller units. Many aspects of medical practice are not responsive to scale, and where scale does help, many of the characteristics of health care

that benefit from integration can be achieved without consolidation but by better use of technology.

A legislative proposal to improve health care quality that manages cost would support local competition between providers and choice for patients. We need to improve productivity and preserve entrepreneurship, autonomy, and local competition that have long been the hallmarks of American medical progress. Thank you.

[The prepared statement of Dr. Gottlieb follows:]

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United States House of Representatives
Statement before the Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
September 10, 2015

THE STATE OF COMPETITION IN THE HEALTH CARE MARKETPLACE

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S IMPACT ON COMPETITION

Scott Gottlieb, M.D.
Resident Fellow
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The views expressed in this testimony are those of the author and do not necessarily represent those of AEI.

Introduction

The healthcare sector is undergoing a secular consolidation as payers and providers assume a historic level of mergers and acquisitions. These trends were underway prior to implementing the Affordable Care Act. But there's little question that ACA hastened them.

While we've seen other waves of consolidation sweep the health services sector, (most recently in the late 1990s); the current series of mergers and acquisitions is different. It's wider, and more sustained. It's unfolding on an industry that was already heavily consolidated. As a result, the impact on patients is more profound and enduring.

I want to focus on the consolidation underway in the market for physician services. By some estimates, care delivered by doctors accounts for 20% of national health spending in the United States[1] and 3.6% of GDP (representing more than $515 billion in 2010,[2] a figure that's equivalent to a third of the economic activity of the entire Canadian economy[3]).

The consolidation of physicians at the local level has served to reduce competition. In the end, most healthcare delivery is local. Once an institution has monopolized most of the providers in its market, it renders market-based reforms hard to achieve, and reduces the ability of competition to be used as a tool for improving quality and holding down costs.

To give a full measure of the scope of consolidation that's underway, I'll briefly recount some of the recent trends in the hospital and managed care sectors as well. I'll discuss how these developments also factor into the trends underway when it comes to physicians.

It's important to remember that the scope of consolidation that we're seeing in healthcare is not a response to market factors. Rather, it's a deliberate function of recent policy choices.

Even if some of these mergers and acquisitions were inevitable, and some of these trends were underway prior to passage of the ACA, that law envisioned that providers would consolidate. The ACA was predicated on the kinds of changes unfolding in the way healthcare is delivered. They are a necessary precursor to many of the ACA's constructs.

The same policy prerogatives driving consolidation in the market for physician services are also stoking mergers and acquisitions in the hospital and health plan sectors. In the hospital sector, 100 merger deals were completed in the sector in 2014 -- up 14% from the previous year, according to Wall Street research firm Irving Levin Associates. For 2015, there is likely

[1] Micah Hartman, Anne Martin, Patricia McDonnell, Aaron Catlin, and the National Health Expenditure Accounts Team. National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998 http://content.healthaffairs.org/content/28/1/246.abstract
[2] Martin, et al., 2012
[3] OECD, 2011

to be even more deals closed. These trends are up sharply from 50 to 60 deals that were announced annually in the pre-ACA years of 2005–2007.[4]

The consulting firm Booz & Co. predicts that 1,000 of the nation's roughly 5,000 hospitals could seek out mergers in the next five to seven years.[5] What's particularly notable about the recent transactions is that the deals are both "horizontal" and "vertical." In other words, the hospitals aren't just buying other hospitals. In many cases, they're purchasing physician practices, rehabilitation facilities, nursing homes and other ancillary healthcare providers.[6]

In the managed care sector, there are similar trends underway, with some large merger deals announced in just the last few months. But the impact of this consolidation is being experienced differently across the different segments of the insurance industry. What's happening in the commercial space is not the same as what's unfolding in Medicare.

In the commercial market for private coverage, there's been a contraction in the number of carriers offering health plans. The problems aren't the mergers per se, but policies that make it difficult for new health plans to enter the market and replace those that are eliminated.

For example, startup health plans often must channel more of their revenue into their initial operating expenses to help pay for the costs associated with launching a new health plan. But controls placed on the operating margins of health plans, limiting how much money they can spend on administration, has made it more difficult for new health plans to get started.

As a consequence, there has been very little investor capital entering this space, and little new de novo plan formation. Under the entire Obama presidency, there has been no net new plan formation. Only about 50 new health carriers have entered the commercial market since 2008, according to a November analysis from Goldman Sachs. Half of these are the struggling not-for-profit co-op plans that the ACA subsidizes. At the same time, around 40 health plans have also left the market over this same stretch of time. Many of these plans merged with competitors, but at least 13 were shut down or liquidated.[7]

Working with research staff at the American Enterprise Institute, I developed data that shows even fewer new health plans entering the market since 2008. We defined new entrants as health carriers or provider organizations that sold health insurance plans sometime between 2008 and 2015 and had never before offered coverage in the market. We found only 38 new entrants. Of these plans, 23 were co-ops, 6 were provider-sponsored plans being offered by hospitals or health systems, and only 7 were new commercial carriers.

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[4] A wave of hospital mergers. The New York Times. August 12, 2013 (http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0)

[5] Julie Creswell and Reed Abelson. New Laws and Rising Costs Create a Surge of Supersizing Hospitals. The New York Times, August 12, 2013. http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?pagewanted=2&_r=0

[6] Hospital Consolidation: Can It Work This Time? May 11, 2015, Wharton School of Business. http://knowledge.wharton.upenn.edu/article/hospital-consolidation-can-it-work-this-time/

[7] Scott Gottlieb. How the Affordable Care Act Is Reducing Competition. The Wall Street Journal, July 5, 2015. http://www.wsj.com/articles/how-the-affordable-care-act-is-reducing-competition-1436136236

The market for commercial plans, however, stands in contrast to what's unfolding in the Medicare Advantage market. There, despite consolidation that has concentrated more plans in the hands of a smaller number of very large carriers, there is still new plan formation and new capital being invested behind the creation of brand new health insurance carriers.

In large part, this more vibrant economic activity is being driven by secular trends that are growing the market for Medicare Advantage plans. As a consequence, according to a new analysis released by the consulting firm Avalere Health, at least 28 new parent organizations entered the MA market from 2012 to 2014 and currently offer coverage. Together, these new entrants offer 104 plan options to more than 13.6 million beneficiaries in 24 states.[8] Medicare beneficiaries in 2015 can choose from an average of 18 MA plan options.

This activity is notable in part because the MA plans have been a focus of the recent acquisitions. Observers worry that the consolidation of large health plans will lead to too much concentration of the Medicare business, and fewer choices for beneficiaries.

There's no indication that the Medicare Advantage market is suffering the same stagnation as the commercial plan space. On a relative basis, investors have perceived Medicare plans as a more attractive market in recent years. Secular trends that are growing the MA market are a big factor, as is the relative value of Medicare business when compared to traditional commercial plans, where there is increasing unpredictability and shrinking profitability.

Medicare enrollment is projected to grow organically to 66 million by 2021 from 54 million today, owing to an aging population.[9] The Medicare Advantage program has been attracting a growing proportion of these new-to-Medicare beneficiaries. Moreover, I believe that the recently enacted "doc fix" is going to continue to drive more beneficiaries into MA plans.

The complexity that the new law creates for providers that see Medicare beneficiaries as part of the program's fee-for-service schedule is going to grow significantly as a result of the provisions in the new law. I predict that more providers are going to opt to see most or all of their Medicare patients under the auspices of one or a few Medicare Advantage plans. While consolidation is shrinking options in an already contracting commercial market, the contours of the Medicare market are different. There is still new investor capital coming into the MA space, new Medicare plans being formed, and a net expansion in the number of offerings.

Physician Ownership as Government Policy

For all the mergers that are underway in the hospital and plan sectors, the activity still dwarfs the scope of a historic consolidation of physician practices. In most cases, doctor practices

[8] Avalere analysis of 2015 Medicare Advantage Landscape File and June 2015 Medicare Advantage Enrollment File. New MA entrants are parent organizations who did not contract with Medicare in 2011 but who did contract in 2012, 2013, 2014, or 2015 and who remain under contract in 2015. Analysis does not count PACE, Cost, or Duals-Demo plans as Medicare Advantage plans.
[9] 2015 Medicare Trustees Report

are being acquired by hospitals to form regional health systems, where a single hospital will control a significant number of the physicians in the outlying community.

This trend toward ownership of physician practices is not new. But like the consolidation underway in the hospital and plan space, this time, things may be much different.

The relationships that doctor practices are forging with their acquiring entities are far stickier than past arrangements. Moreover, for doctors, the opportunity to unwind these business engagements, and go back to their old configurations, are much more narrow. There is far more reason to believe that the new, consolidated doctor arrangements will persist.

In the past two decades, there have been at least two other waves of consolidation, where doctors were merged into health systems and hospitals. During each of these periods, physicians typically entered into employed relationships with the acquiring entities.

The first wave came with the advent of the for-profit physician practice management companies (PPMs) in the late 1990s. The model was premised on a view that PPMs could exploit cost savings through economies of scale and centralization, expanded access to capital, and bargaining clout with managed care companies. Most of the PPMs foundered, in part because they couldn't deliver on the promised efficiencies, and in part because they had promised high up-front payments to acquire the doctor practices and then couldn't recoup these investments. Most of the venture backed PPMs were liquidated. Doctors who had joined them dislodged their practices and went back to running their own medical offices.

The second major era of physician consolidation also unfolded in the 1990s, when hospitals made their first major foray into acquiring medical practices. These acquisitions were driven by the adoption of managed care in the 1990s. Hospitals and health systems became concerned that they would be excluded from contracting as HMOs started to shift risk onto providers through capitated arrangements. The providers, bearing financial risk, would adopt measures to avoid costly referrals to the hospital, or steer their patients only to low cost institutions. Or so the theory went. In a defensive bid to preserve market share, the hospitals started to acquire the doctors so that they could control their referral patterns.

These same concerns were part of the initial economic thesis behind the creation of the practice management companies. The belief was that the PPMs could also consolidate physicians, implement management tools that would enable the PPM to get more control over the doctor's clinical practice, and then contract directly with the HMOs to service the risk-bearing contracts. At the same time that hospitals were buying up doctor practices in many communities, they were also facing active competition from the investor-owned PPMs such as Phycor and MedPartners that were also purchasing large physician groups.

But the push toward capitation and narrow network HMOs receded, largely a consequence of a consumer and political backlash to the restrictive practices that shifted financial risk for medical care onto providers. This countermovement eventually led to the introduction of the Patients Bill of Rights in Congress.[10] Economics also played a role. In many cases,

[10] Despite apparent bipartisan support, the 105th Congress failed successively to pass legislation protecting the rights of patients enrolled in managed care. See Clinton Signs Act Streamlining FDA Approval Of New Drugs,

owning doctors proved to be a money-losing proposition. Hospitals found that they were sustaining operating losses on these practices in excess of $80,000 per physician.

The hospitals responded by rapidly divesting the practices once the trend toward managed care and capitation subsided. It was not profitable to own doctors, and it was no longer a strategic necessity. A handful of large, integrated delivery systems managed to survive. These include Intermountain Health and Geisinger Health System – two delivery systems that developed their modern footprint during this wave of physician consolidation. It should come as no coincidence that the systems that managed to survive, and prosper, by owning doctors under these integrated arrangements also had certain unique marketplace features.[11]

It's been noted that both of these efforts – one well-funded and predicated on expected profit opportunities, and the other formulated by insiders and created for supposed strategic advantages – have largely failed. Combined with the limited organic growth of group practices, this suggests that the economics of physician practice may be more complicated than perceived. The presumed economies of scale and scope of larger physician practices are illusory. That is, the small physician practice may in fact be economically robust.[12] Such considerations don't seem to have given any pause to pursuing these same concepts again.

The Third Wave of Physician Consolidation

We are now experiencing the third wave of physician consolidation. This time, it's not business factors alone that are driving these mergers. This time, the consolidation is a consequence of deliberate policies designed to instigate these marketplace changes.

The ACA envisions doctors practicing in large, integrated health systems, often with a hospital at its hub. The newly consolidated entities need to be big enough to take capitated risk and invest in the kinds of technologies that, it's believed, will lead to better coordination of medical care. The ACA's mix of policies seeks to hasten these outcomes.

This isn't just an economic prerogative. It's the triumph of a political philosophy. In the early 2000s, Republicans made a concerted push toward "consumer directed healthcare." The notion was that, by empowering consumers to engage more actively in their medical care, and by exposing them to some of the incremental costs of their healthcare decisions, consumers would help control health spending and lead to more optimal medical decisions.

These concepts formed the basis for policies contained in the Medicare Modernization Act, including the expansion of Health Savings Accounts, the private delivery of Medicare benefits, and efforts to improve the information that consumers had to make decisions.

Endorses Patient 'Bill Of Rights,' Buffalo News, Nov. 21, 1997, at A16; Marilyn Chase, Work in Progress, New 'Bill of Rights' Makes a Modest Start at Protecting Patients, Pittsburgh Post Gazette, Dec. 2, 1992, at E4.

[11] For example, many enjoyed geographic isolation that limited their local competition.

[12] Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11

Liberals largely rejected these concepts. Their opposition turned on a number of concerns. First, there was a belief that many consumers aren't able to make optimal medical decisions owing to the complexity of medical care and the information asymmetries that persist in the doctor-patient relationship. Liberals also worried that consumers would forgo necessary care if they had to foot some of the bill, or wouldn't be able to afford the resulting cost sharing.

Finally, opponents of the consumer-driven policies believed that people shouldn't be forced to contemplate economic considerations when they were confronted with illness. There were other concerns, but these were the principal considerations to the opposition. To these ends, the ACA represented a wholesale rejection to many of the provisions of the Medicare Modernization Act and the Republican-led effort to implement consumer-driven healthcare.

But under a system dominated by third party payment for medical care – where consumers are not directly involved in paying for services -- there are only several ways to instill some restraint on the demand for services, if that discipline doesn't reside with the consumer.

These considerations can reside with the government, through constructs that aim to control price and access through national coverage decisions. To some degree, the ACA relies on these approaches, for example by giving the Centers for Medicare and Medicaid Services broad authority to tweak "mispriced" codes and become more actively engaged in using payment as a tool to control demand. The Independent Payment Advisory Board is also a personification of these ideas. But creating more explicit policy tools for rationing care is fraught with political risk. The rationing decisions become obvious.

So the ACA takes the final path. It puts these decisions on doctors, through arrangements that transfer risk for the cost of medical care directly onto physicians. It's a throwback to the 1990s practice of capitation, with new acronyms ascribed to the measures. Yet putting doctors on the hook for making these rationing decisions is the least transparent place for these considerations to reside. Patients may never know the options they weren't offered.

A Throwback to 1990s Capitation

These concepts pre-date the 1990s. Congress passed the Health Maintenance Act of 1973 in response to growing healthcare costs, as a way to provide government support to these ideas.[13] But they didn't gain wide adoption until the 1990s, in response to escalating healthcare costs that sent businesses search for a way to manage demand for healthcare.

[13] Under the Federal HMO Act, the federal government approved loans and grants to entrepreneurs interested in creating HMOs that met federal requirements. In order to receive financial assistance from the government, an HMO had to abide by certain requirements set forth in the Act. The rules and regulations provided a structure that the HMOs had to follow to assure quality health care. The Act also required HMOs to assume all responsibility for health care services on a prospective basis. However, the 1973 Act also permitted physicians contracted by the HMOs to assume financial risk for the rendering of health care services.

The HMOs made doctors responsible for the financial cost of caring for defined populations of patients.[14] Doctors got a fixed sum of money for taking responsibility for a panel of patients. If caring for that panel ended up costing more than the contracts allowed, doctors absorbed the loss. If the physicians spent less money than they were allotted, they kept the excess revenue as profit, and as a financial inducement to closely manage the cost of care.

Consumers rejected these capitated models, largely out of concern that these arrangements confronted doctors with a financial conflict.[15] [16] [17] Physicians earned more money when they made decisions – subtle or overt -- to withhold medical care.[18] These concerns were heightened by "gag" clauses that the HMOs maintained in their contracts with doctors. The provisions sought to prevent doctors from discussing these tradeoffs with patients.[19] [20]

The ACA should be viewed as nothing short of a wholesale re-embrace of these capitated arrangements and the concept of shifting financial risk onto providers. To enable this risk taking, the ACA adopts a series of measures designed to change the organization and delivery of medical care in order to make the practice arrangements more economically amenable to taking on capitated risk. The physician consolidation (mostly around hospitals) is a key part of this new political economy. In response to the concerns, progressives argue that the shortcomings of these arrangements – in particular, the conflict that the doctor faces between providing care and maximizing profit -- can be reduced through proper regulation.

The economic behind these arrangements raise some more fundamental questions. For one thing, these constructs were, in part, a response to criticism of the fee-for-service approach to payment, which is widely presumed to give doctors a financial incentive to prescribe more

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[14] See Alycia Regan, Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care, J.L. & Soc. Probs. 635, 637 (1997) (describing the growth of managed care). Since 1993, MCOs have dramatically grown in number and expanded into new markets. In 1995, approximately 19% of Americans were enrolled in health maintenance organizations (HMOs). It is estimated that 73% of Americans who receive health insurance through their employers are enrolled in MCOs. "[T]his increasing reliance on managed care may be traced to a growing belief among employers and legislators that health care costs were spiraling out of control and that the traditional medical system could not adequately contain those costs."

[15] Diana Bearden & Bryan Maedgen, Emerging Theories of Liability in the Managed Health Care Industry, 47 Baylor Law Review. 285, 294-95 (1995)

[16] Ralph O. Bischoff & David B. Nash, Managed Care: Past, Present, and Future, 80 Medical Clinics of North America. 225 (1996)

[17] Deven C. McGraw, Note, Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?, 83 Georgetown Law Journal. 1821, 1825 (1995)

[18] David Orentlicher, Paying Physicians More to do Less, 30 University of Richmond Law Review. 155, 155-64 (1996); see also James Freiburg, The ABC's Of MCOs: An Overview of Managed Care Organizations, 81 ILL. B.J. 584 (1993) (arguing that the term "managed care" is misleading because it is not really care at all, rather it is a comprehensive term describing a system of health care cost containment)

[19] Diane Swanson, Comment, Physician Gag Clauses - The Hypocrisy of the Hippocratic Oath, 21 S. ILL. U. L.J. 313, 315-16 (1997) (discussing gag clauses and their impact on health care). The author notes that MCOs use a drastic mechanism known as a gag clause to preclude physicians from criticizing managed care plans. See id. at 314-16. "Gag clauses are provisions in physician contracts which prevent them, explicitly or implicitly, from giving patients information about treatment options that may not be covered by their health plan." AMA Takes Stand Against Health Plan 'Gag' Rules, West's Legal News, July 12, 1996, available in 1996 WL 382081. In essence, a gag clause constrains free and unfettered discussion between a doctor and patient.

[20] Julia Martin and Lisa Bjerknes. The Legal and Ethical Implications of Gag Clauses in Physicians Contracts, 22 American Journal of Law and Medicine. 433, 434 (1996).

care. As the analysis commonly goes, under FFS arrangements, doctors are paid more when they do more things, and not necessarily when they improve outcomes.

But in reaction to these concerns, have we merely traded one flawed set of financial incentives for another? After all, if the financial incentives work in one direction, they have to work in the opposite direction. If doctors will prescribe unnecessary care when they're paid to do more, as critics of FFS medicine maintain, won't these same inducements work in reverse? Won't doctors prescribe less care when they are paid more to do less?

This raises another key question, this one clinical. Are patients better off, on the whole, when they're prescribed a little more care then they need, or a little less? The body of clinical literature doesn't fully resolve this question. Where studies try and tackle this question, many of the analyses seem to adopt methodologies that are colored by policy assumptions of the authors. The answer probably varies widely based on the clinical circumstance.

Another consideration is the propriety of these constructs. If nothing else, the capitated arrangements are the least transparent form of rationing. This seems to be part of their political appeal. When doctors make decisions to withhold some aspect of medical care out of a consideration of its cost, the patient may never know the option that they weren't granted. This remains the central concern over these arrangements.

But political opposition to these constructs has receded since they were first adopted, and then abandoned, in the 1990s. These ideas now form a central part of the ACA's premise, and a key rationale for the law's efforts to re-structure the organization and delivery of care.

To enable these constructs, the belief was that the organization of physicians had to change. Doctors had to be organized in larger units that were capable of taking on the capitated risk.

The advent of the Accountable Care Organizations was always perceived by the ACA's architects as an interim step toward these outcomes. In these goals, the ACA has been largely successful. Different surveys peg the numbers differently, but all point to greater consolidation of physicians into salaried roles, usually with a hospital or hospital-based health system at the center. One survey of some 20,000 U.S. doctors found that 35% described themselves as independent, down from 49% in 2012 and 62% in 2008. In another large survey, from 2007 to 2013, nearly 10% of physicians sampled were acquired by a hospital, increasing the share of physicians that are hospital owned by more than 50%.[21]

In 2010, full- and part-time hospital employment of physicians represented more than 15% of all practicing physicians.[22] A detailed analysis done that year of the membership of the Medical Group Management Association found hospitals employed roughly 28% of the

[21] Cory Capps, David Dranove, Christopher Ody. Institute for Policy Research Northwestern University, Working Paper Series WP-15-02. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending, February 2015. http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf

[22] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf

212,000 physicians practicing in MGMA member groups — about 60,000 physicians.[23] Another 27.3% of MGMA group physicians (almost 58,000) practice in various other non-physician-owned groups such as IIMOs and medical school faculty practice plans.

These trends have continued since then, with more doctors continue to take on employed relationships, selling their medical practices – mostly to hospitals. To recap some other published surveys: Since passage of the ACA, neurologists report an 8% increase in academic practice settings, a 2% decrease in private practice settings, and a 5% decrease in solo practice settings. Surveys of family physicians showed that 60% are now employees of hospitals or larger groups.[24] In another survey, from 2004 to 2011, hospital ownership of primary care physician practices increased from 24% of practices to 49%.[25]

Another survey conducted by the American Hospital Association (AHA) reported that about 15% of all physicians were full or part time hospital employees as of 2010. Of this number, 12.2% were reported to be full-time employees.[26]

Not all of the consolidation is through outright purchases of medical practices. Some of the consolidation is through contracting. Tax and regulatory considerations sometimes make it more advantageous, in certain circumstances, for a practice to sell its physician infrastructure to a hospital and then contract its services, for example. To these ends, research by the Deloitte Center for Health Solutions found that 60% of primary care practices are now exclusively aligned with a single hospital, though not necessarily employed by it.

The shift is more pronounced in medical specialties where there's a larger financial arbitrage between Medicare's generally lower-paying outpatient reimbursement and its higher-paying inpatient billing schemes.[27] Researchers at the Center for Studying Health System Change examined nearly 600,000 private insurance claims and found that average hospital outpatient department prices for common imaging, colonoscopy, and laboratory services are double the price for identical services provided in community settings. For example, the average price of a colonoscopy in a hospital was $1,383 compared with $625 in an outpatient setting.[28] In many of these cases, by acquiring medical practices, hospitals are able to capture more revenue. Medicare will reimburse more for services when they're performed in hospital ambulatory clinics rather than in a doctor's private office.

Cardiology is the most prominent example where hospitals are playing this arbitrage, in part owing to coding adjustments ushered in by the ACA that made it far more profitable to perform procedures like stress tests and echocardiograms in the hospital outpatient setting, rather than a private office. As a result of these reimbursement changes, between 2007 and

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[23] Fabrizio, 2012

[24] Elaine C. Jones, and David A. Evans. Defending the solo and small practice neurologist. Neurol Clin Pract April 2015 vol. 5 no. 2 158-163 http://cp.neurology.org/content/5/2/158.short

[25] http://scholar.harvard.edu/files/cutler/files/jsc130008_hospitals_market_share_and_consolidation.pdf

[26] Elliott, 2012

[27] Medpac Report to Congress, June 2013. Medicare payment differences across ambulatory settings. http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0

[28] National Institute for Health Care Reform (NIHCR), authors Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services. Washington, DC: NIHCR; June 2014. (NIHCR Research Brief No. 16).

2012, the number of cardiologists working for hospitals more than tripled, according to a survey from the American College of Cardiology.[29] Over the same period, the percentage of cardiologists working in private practice fell to 36% from 59%. At the time of the survey, an additional 31% of practices were either in the midst of merger talks or considering it.

Oncology provides another example where this arbitrage exists, especially when it comes to the higher rates paid to the infusion of chemotherapy in the hospital outpatient department. This has caused a massive shift of oncology providers into hospitals.

Between 2005 and 2011 the amount of chemotherapy infused in doctors' offices fell to 67%, from 87%, according to an analysis of Medicare billing data done for community oncology groups. The share of Medicare payments for chemotherapy administered in hospitals (as opposed to outpatient oncology practices) increased to 41% in 2011, from 16.2% in 2005. The ACA's expansion of the 340B program is also driving these trends.[30]

This has a particularly profound effect on rural markets, where patients can find harder to receive care at a site near their homes.

It also affects costs. Because the overhead for a hospital is higher than for a doctor's office, a patient treated in a hospital clinic incurs $6,500 more in costs than the same person treated in a private medical office, according to data from the Community Oncology Alliance. Patients who get chemotherapy at a hospital also face an additional $650 in co-pays and other out-of-pocket expenses. The price for infusing the drugs alone rises by 55%, according to an analysis of Medicare data. These inflated prices for cancer treatment inevitably drive up the cost of health insurance.[31]

How the ACA Drives Physician Consolidation

As noted, the ACA is driving this consolidation as a key part of its economic principle. The ACA is crafted on a premise that excess healthcare spending is a consequence of inefficient delivery and unnecessary utilization. The FFS physician payment system, it's argued, is a key driver of excessive utilization. So is the fragmented structure of the delivery system.

To ameliorate these shortcomings, the ACA changed payment rules, and advanced other constructs, as part of an effort to consolidate providers into integrated delivery systems, usually with a hospital as the central hub. These constructs were viewed as a gateway to the payment reforms advanced by the ACA. There was hardly a single speech that President Obama gave on the topic of healthcare reform where he didn't use one of the purported models for these designs – institutions such as Mayo Clinic, Geisinger Health, or

[29] http://www.nccacc.org/news/2012USCVPracticeCensusNorthCarolina.pdf
[30] Scott Gottlieb. How ObamaCare Hurts Patients. The 340B program was meant to help about 90 hospitals buy drugs to treat the poor. Now 1,675 hospitals qualify. The Wall Street Journal, July 30, 2013 http://www.wsj.com/articles/SB10001424127887324110404578630522319113676
[31] Scott Gottlieb. How ObamaCare Hurts Patients. The 340B program was meant to help about 90 hospitals buy drugs to treat the poor. Now 1,675 hospitals qualify. The Wall Street Journal, July 30, 2013 http://www.wsj.com/articles/SB10001424127887324110404578630522319113676

Intermountain Health – as the standard for his reforms. The ACA seeks to replicate these institutions nationwide, even though their successes had more to do with local traditions and superior management. That's hard to engineer through legislation.[32] Nonetheless, to try and duplicate these constructs, the ACA adopted specific provisions to drive such consolidation.

These ACA-led provisions can be broken into four broad categories:

1. The Bias Toward ACOs: Payment rules were deliberately biased against independent doctors and toward models where physicians were in employed relationships as part of health systems. In particular, the ACA envisions the creation of Accountable Care Organizations (ACOs) -- integrated health systems that are, in many respects, a throwback to the 1990s concept of Physician Sponsored Organizations (PSOs).

Many supporters of these concepts in the ACA argue that the ACOs were not the inevitable goal, but merely an interim construct. The ACOs were, in this analysis, devised as a way to condition providers to take on risk, and a way to develop the incentives that would create the kinds of organization to make it possible for providers to take this capitation.

These constructs are tied to new payment rules that try to link pay to performance. Doctors will see their income decline unless they're practicing as part of these new arrangements. Small practices will be disadvantaged in these programs because they lack sufficient patient caseloads to demonstrate statistically reliable measures that these new schemes demand.[33]

Smaller, independent practices also lack the footprint to form the arrangements that will make them eligible for these new payment schemes.

For one thing, provider practices that want to participate in the "reformed" physician payment plan must control their own IT infrastructure to comply, as opposed to collaborating freely across space rented in the cloud. This practical need can require IT infrastructure that costs millions of dollars. It can make participation in these programs prohibitively expensive for anyone but a hospital that already has its own server hub.[34]

Also, waivers of certain anti-kickback provisions (that prevent doctors from forming needed business partnerships) only apply when providers qualify as an ACO.[35] [36] But ACO qualification is largely dependent on requirements that create the same need for physical infrastructure and bureaucratic overhead that's hard to replicate outside the hospital setting.[37]

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[32] Scott Gottlieb. The Doctor Won't See You Now. He's Clocked Out. The Wall Street Journal, March 14, 2013 http://www.wsj.com/articles/SB10001424127887323628804578346614033833092

[33] Nyweide et al., 2009

[34] Scott Gottlieb. ObamaCare's Threat to Private Practice. The Wall Street Journal, December 7, 2014. http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367

[35] Robert G. Homchick and Sarah Fallows. ACOs: Fraud & Abuse Waivers and Analysis. Davis Wright Tremaine, LLP. https://www.healthlawyers.org/Events/Programs/Materials/Documents/HCT13/h_homchick.pdf

[36] Lisa Schencker. HHS extends Stark, anti-kickback waiver for ACOs. Modern Healthcare, October 17, 2014. http://www.modernhealthcare.com/article/20141017/NEWS/310179934

[37] Scott Gottlieb. ObamaCare's Threat to Private Practice. The Wall Street Journal, December 7, 2014. http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367

2. Paying More for Hospital Care: Payment was skewed toward the inpatient delivery of care, by reducing payment for outpatient procedures while increasing (or holding steady) the reimbursement when the same procedures are done in the outpatient hospital setting.[38]

This is especially true for certain cardiology procedures. The differentials have been a big factor behind the rapid consolidation of cardiologists. These "site of service" pay differentials enable hospitals to charge more for physician services provided in a hospital outpatient setting than when the same services are provided in a private practice. The pay disparities are significant factor driving the hospital-based ownership of doctors.[39]

A March 2013 report by the Medicare Payment Advisory Commission found that an office visit with a physician in a hospital outpatient department is reimbursed at a rate 80% higher than the same procedure performed in a physician's office. As a result, the report cites a steady shift of services from physicians' offices to outpatient departments from at least 2009, "consistent with the financial incentives in the current payment system." MedPAC "expressed concern that higher payment rates in OPDs [outpatient departments] may induce hospitals to acquire physician practices and deem these practices part of the OPD."[40]

The figures suggest that on only two services—evaluation and management visits and echocardiograms—Medicare paid hospitals $1.3 billion more in 2010 than they would have paid if the services had been performed in a physician's office rather than an outpatient department, MedPAC reports. In 2011, that number rose to $1.5 billion.[41]

3. Rising Costs, Wilting Revenue: At the same time, doctors saw their profitability reduced. Government rules increased their practice costs while reducing their revenue under Medicare. At the very best, doctors have seen their Medicare reimbursement levels held largely flat, even while the rise in their medical practice costs continues to outpace inflation.

According to one survey of 5,064 physicians conducted in 2014 by CareCloud and QuantiaMD, 39% of all physicians foresee their profitability eroding, not increasing, up from 36% in 2013. Issues weighing on their finances are led by declining reimbursement (60%), rising costs (50%), requirements from the ACA (49%), and the transition to ICD-10.[42]

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[38] Anna Wilde Mathews. Same Doctor Visit, Double the Cost, Insurers Say Rates Can Surge After Hospitals Buy Private Physician Practices; Medicare Spending Rises, Too. The Wall Street Journal, August 27, 2012. http://www.wsj.com/articles/SB10000872396390443713704577601113671007448

[39] Hospitals Bristle as MedPAC Warns of Controversial Billing Initiative. At issue is how much large provider systems can charge for services after they've acquired physician practices. Managed Care Magazine, July 2013. http://www.managedcaremag.com/archives/2013/7/hospitals-bristle-medpac-warns-controversial-billing-initiative

[40] Medpac Report to Congress, June 2013. Medicare payment differences across ambulatory settings. http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0

[41] Scott Baltic. Monopolizing medicine: Why hospital consolidation may increase healthcare costs. Medical Economics, February 24, 2014. http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full

[42] The Second Annual Practice Profitability, Carecloud and QuantiaMD. 2014 Edition. http://on.carecloud.com/rs/carecloud/images/PPI-Report.pdf

4. Combatting Narrow Networks: Finally, the growing propensity of exchange-based plans to contract with narrow networks of doctors, as a way to reduce costs and utilization, has put physicians at risk of being excluded from managed care contracts. These narrow networks were a significant part of the economic thesis supporting the ACA.

The law's architects envisioned health plans using restrictive networks as the primary tool for cost control. Other traditional ways that plans try and control costs – among them, by changing their benefit design, increasing their cost sharing, and underwriting risk -- were largely banned by the ACA. As a result, the principal tool plans were left with was their ability to control utilization. And the primary way to control utilization is to get more leverage over providers. The health plans achieved these ends either by owning the doctors outright, or by contracting with a more selected number of providers.[43] [44] [45]

In most cases, the doctors prefer to sell their practices to hospitals. So the insurers are left with narrow networks as their principal tool for managing costs. As a defensive response to these narrow networks, and to make sure they don't get excluded from managed care contracts, the doctors themselves are merging or forming businesses alliances. This is how consolidation begets still more consolidation in the sector.[46]

Consolidation Reduces Clinical Productivity

As the Physicians Foundation notes,[47] compelling economies of scale are not apparent in physician practice. This has been borne out by studies that examined the question. A recent economic analysis by Douglas Hough of Johns Hopkins and David Gans of MGMA, for example, found scale economies in physician practice to be elusive. The survey examined 1,647 medical practices. Using 2008 data on the cost of medical care, physician productivity (as measured by gross physician revenues per full time equivalent physician) actually declined as medical groups grew in size from one to eight. It rose only modestly in groups of more than eight. For primary care specialties like family practice, the negative returns to scale continued until the group size reached 25. Keep in mind that the average family practice group size is six doctors. After that level, modest incremental revenue growth was seen.[48]

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[43] http://www.nytimes.com/2014/03/06/opinion/in-health-care-choice-is-overrated.html?ref=topics

[44] Bruce Japsen. Patients' choices may narrow as insurers adjust standards for doctors, hospitals - Quality measurements raise concerns about conflict between best care, cost controls. The Chicago Tribune, September 04, 2010. http://articles.chicagotribune.com/2010-09-04/business/ct-biz-0825-network-choices-20100904_1_doctors-and-hospitals-care-hmo-illinois

[45] Kocher, Robert, Ezekiel J. Emanuel, and Nancy-Ann M. DeParle, (2010). "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges," Annals of Internal Medicine, vol. 153, (8), Oct. 19, pp. 536-39.

[46] Martin Gaynor. Statement before the Committee on Ways and Means, Health Subcommittee. Health Care Industry Consolidation. September 9, 2011.
http://waysandmeans.house.gov/UploadedFiles/Gaynor_Testimony_9-9-11_Final.pdf

[47] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation
http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf

[48] Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11

What's going on?

Part of the issue seems to turn on practice productivity. There's evidence that as doctors transition into becoming salaried employees of hospitals and health systems, their individual productivity (in terms of metrics such as volume and intensity of care delivered) generally declines outright, or is unfavorably impacted by these arrangements in other, more subtle ways.[49 50 51 52 53] Analyzing the source of the hospitals' physician practice losses, MGMA found that practice expenses for hospital-operated physician groups were actually 8% lower than those of non-hospital MGMA member groups. However, physician productivity in hospital employment was far lower. Net collected revenues for hospital-owned practices were more than $100,000 per FTE physician lower than revenues for physician-owned practices and an impressive 35% lower than better performing practices. This result is, in large part, of markedly lower physician productivity.[54]

It's important to note that studies that have examined this question contain many limitations. This is because of the inherent difficulty in studying the impacts of different payment systems as well as the lack of good metrics for assessing physician productivity.

Many of the studies also rely on measuring Relative Value Units, which probably don't capture the full measure of a doctor's productivity. The RVUs are a formula that Medicare already uses to set doctor-payment rates. RVUs are supposed to measure how much time and physical effort a doctor requires to perform different clinical endeavors.

Medicare assigns each clinical procedure a different RVU and then multiplies this figure by a fixed amount of money to arrive at how much it will pay a doctor for a given task. A routine office visit has an RVU of about 1.68, while removing earwax has one of 1.26. Setting a finger fracture rates a 3.48. But this system misses the intangible factors that help gauge the quality and efficiency of the care being delivered. It can focus physicians on the wrong goals for promoting health, such as how well they code charts to capture higher-value "units."[55]

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[49] Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. Milbank Quarterly 2008;86:375–434

[50] Christopher D. Ittnera, David F. Larckerb, Mina Pizzinic. Performance-based compensation in member-owned firms: An examination of medical group practices, May 2007

[51] Wolinsky F, Marder W. Spending time with patients, the impact of organizational structure on medical practice. Medical Care 1982; 20(10):1051–9

[52] I S Kristiansen, K Holtedahl. Effect of the remuneration system on the general practitioner's choice between surgery consultations and home visits. Journal of Epidemiology and Community Health 1993;47:481-484

[53] Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. Journal of Health Service Research Policy 2001 Jan;6(1):44-55

[54] Advisory Board, 1999

[55] Scott Gottlieb. The Doctor Won't See You Now. He's Clocked Out. The Wall Street Journal, March 14, 2013 http://www.wsj.com/articles/SB10001424127887323628804578346614033833092

As a result of the shortcomings of assessing productivity by measuring RVUs, the studies may actually understate the loss of productivity that results from the physician acquisitions.[56]

The data does show some offsetting economic impacts to these drops in productivity. For example, physicians' use of services such as diagnostic tests demonstrate a corresponding decline when doctors move into salaried arrangements. The totality of the data suggests, however, that the reduction in costs generated by the salaried schemes (typically as a result of the delivery of fewer diagnostic tests) may be partially, if not completely offset by the lower intensity of work (productivity) that physicians achieve under these arrangements.[57]

While it's generally hard to isolate the impact of payment structure on productivity, a number of other studies have attempted to assess these impacts. I summarized some of this literature in prior testimony I delivered before the Ways & Means Committee in May 2012.[58]

In one study, researchers used a resident continuity clinic to compare prospectively, the impact of salary versus fee-for-service reimbursement on physician practice behavior. This model allowed randomization of physicians into salary and fee-for-service groups, therefore enabling the separation of the effects of reimbursement from patient behavior.[59]

The authors found that physicians reimbursed by FFS scheduled more visits per patient than salaried physicians (3.69 visits versus 2.83 visits, $P < .01$) and saw their patients more often (2.70 visits versus 2.21 visits, $P < .05$) during the 9-month study. FFS physicians also provided better continuity of care than salaried doctors by attending a larger percentage of all visits made by their patients (86.6% of visits versus 78.3% of visits, $P < .05$), and by encouraging fewer ER visits per enrolled patient (0.12 visits versus 0.22 visits, $P < .01$).[60]

Another review article surveyed the available literature examining how salaried arrangements impact physician productivity. It drew similar conclusions. The article found that salary payment reduces activity compared with fee for service. Capitation appeared to have a similar but more subdued effect. The authors concluded that "if cost containment is a key policy aim of government then salaried payment systems are more likely to achieve this compared with FFS and possibly more effective than capitation systems. However, cost containment by itself may be inefficient if it results in the provision of sub-optimal care."[61]

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[56] Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. Cochrane Database Systematic Reviews 2000;(3)

[57] T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47-55

[58] http://www.aci.org/wp-content/uploads/2012/05/-scott-gottlieb-testimony_094622558298.pdf

[59] Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344-350

[60] Gerald B. Hickson, William A. Altemeier, James M. Perrin. Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study. Pediatrics 1987;80:344-350

[61] T. Gosden, L. Pedersen and D. Torgerson. How should we pay doctors? A systematic review of salary payments and their effect on doctor behavior. QJM 1999;92:47-55

There's also evidence that smaller practices may actually demonstrate higher productivity than large integrated practices, contrary to conventional wisdom (and certainly contrary to the economic assumptions that underpin the provisions in the ACA).

In one study, the mean multispecialty practice generated more than three times the total gross charges as the mean single-specialty practice, but with almost five times the number of FTE physicians. As a result, the mean multispecialty practice produced 29% less charges per FTE physician ($367,000 versus $515,000). Controlling for practice size, the mean multispecialty practice employed more ancillary, clinical, and office staff and fewer midlevel providers than did the mean single-specialty practice.[62] The per-physician productivity gains from physician ownership are estimated to be $94,000 for all practices, $26,000 for multispecialty physician practices, and $64,000 for single-specialty practices.[63]

This data raises a fundamental choice: If the goal is reduce spending by driving down utilization then the salaried arrangements might provide a more direct means of imposing top-down controls. If the goal is to reduce costs by increasing productivity then the salaried arrangements might thwart these types of outcomes.

Taking a broader assessment of our fiscal challenges when it comes to healthcare, the only way that we are going to solve some of our long-term economic challenges facing entitlement programs like Medicare is to get more healthcare for every dollar of GDP that we spent on it. Under these circumstances, the last thing we ought to be doing is adopting structures that are going to reduce productivity.

Raising the Cost of Healthcare

Studies show the physician consolidation also raises the cost of healthcare to consumers, in part owing to the lost productivity, in part owing to the lost competition that accrues as institutions monopolize their local providers. There's direct evidence that hospital-owned physician practices, in particular, incur higher costs of care than physician owned practices.[64]

One recent study examined total medical spending for about 4.5 million HMO patients in California from 2009 to 2012. The figures reflected the total cost of care, including

[62] Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24

[63] Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24

[64] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9. http://www.ncbi.nlm.nih.gov/pubmed/25335148

hospitalizations, prescription drugs and physician visits. The data were obtained from the Integrated Healthcare Association, which includes insurers and medical providers.[65]

According to this 2012 study of 158 organizations, physician-owned medical provider organizations had mean expenditures of $3,066 per patient (95% CI, $2,892 to $3,240), while hospital-owned physician organizations had mean expenditures of $4,312 per patient (95% CI, $3,768 to $4,857), and physician organizations owned by multihospital systems had mean expenditures of $4,776 (95% CI, $4,349 to $5,202) per patient. After adjusting for patient severity and other factors over the period, local hospital-owned physician organizations incurred expenditures per patient 10.3% (95% CI, 1.7% to 19.7%) higher than did physician-owned organizations (adjusted difference, $435 [95% CI, $105 to $766], P = .02).[66]

Organizations owned by multihospital systems incurred expenditures 19.8% higher than physician-owned organizations (95% CI, 13.9% to 26.0%; adjusted difference, $704 [95% CI, $512 to $895], P < .001). The largest physician organizations incurred expenditures per patient 9.2% higher than the smallest organizations (95% CI, 3.8% to 15.0%, P = .001).

Most of the available studies look at the effects of hospital acquisition of doctors because hospitals have been the largest acquirer of physicians.

A May 2014 Health Affairs study found that when hospitals buy physician practices, the result is higher hospital prices and increased spending. The authors used hospital claims for the non-elderly, privately insured in the period 2001-2007, to construct county-level indices of prices, volumes, and spending and adjusted them for enrollees' age and sex. They measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians.

The study found that an increase in the market share of hospitals with the tightest vertically integrated relationship with physician practices (mostly through ownership) was associated with higher hospital prices and spending. "We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small," the authors write. "Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured."[67]

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[65] Chad Terhune. Study: Medical costs up to 20% higher with hospital-owned physician groups. Los Angeles Times, October 21, 2014. http://www.latimes.com/business/healthcare/la-fi-hospital-physician-costs-20141021-story.html

[66] Of the 158 healthcare organizations that the researchers surveyed, 118 (75%) were physician-owned and provided care for 3,065,551 patients, while 19 (12%) were owned by local hospitals and provided care for 728,608 patients, and 21 (13%) were owned by multihospital systems and provided care for 693,254 patients.

[67] Baker LC, Bundorf MK, Kessler DP. Vertical integration: hospital ownership of physician practices is associated with higher prices and spending. Health Affairs (Millwood). 2014;33:756–763.

The Consolidation creates its own Instability

In part for these reasons, physician ownership is a mixed financial bag for hospitals. Once the arbitrage found in the Medicare rates is inevitably sanded away, many of these new arrangements will become a financial drag on hospitals, and may well strain their solvency.

According to the MGMA, in 2013 the average hospital-employed physician generated more than $206,000 in losses (the difference between total practice revenue and costs of operating the practice). These burgeoning losses have occurred at the same time that hospitals' top lines have stopped growing. The economic facts suggest that any major deterioration of hospital operating profits will put these strategies, and hospital finances at significant risk.[68]

Losses from physician employment were a common theme in recent Moody's reports on the financial health of not-for-profit hospitals.[69] "For hospitals to break even, newly hired PCPs must generate at least 30% more visits, and new specialists 25% more referrals, than they do at the outset… Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities,"[70] Moody's wrote.

It's quite possible that the hospitals rolling up practices have neither the economic resources nor management capacity to absorb a much larger portion of the practicing physicians.[71] These realities, however, don't seem to be slowing the pace of the ensuing consolidation.

This is not a path to higher productivity. It's not a construct that's going to lead to lower costs, or more efficiency. It's not going to improve patient choice. Worse still, the consolidation is not an inevitable consequence of market forces or the demands of patients. Nor is it a failure of government to properly regulate these markets.

It's a direct consequence of a deliberate policy decision to create financial incentives for the formation of these new structures, based on what increasingly appears to be a flawed premise about how physician services should be organized, and medical care delivered.

In large measure, the policy ideas that gave rise to the consolidation are themselves an accommodation to the shortcomings of centrally managed, federally administered healthcare.

Well-managed private health plans are able to more closely evaluate medical care and contract with higher-performing providers. They are able to scrutinize reimbursement and establish rules that try and tie reimbursement to value. But under Medicare's FFS payment

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[68] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf

[69] Beth Kutscher. Making physicians pay off: Hospitals struggle to balance current costs with future benefits of employing docs. Modern Healthcare, February 22, 2014.

[70] Kocher R, Sahni NR. Hospitals' race to employ physicians--the logic behind a money-losing proposition. New England Journal of Medicine 2011;364:1790–1793.

[71] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf

system, the government is too removed from the provision of care to exercise this level of supervision. So compromises must be made. The consolidation of providers into systems that can take wholesale risk for large populations of patients is one such compromise.

It's a concession made to remote, government administration of healthcare.

The Need to Reform the 'Reforms'

Once independent doctors become the exception rather than the rule, the continued advance of the ACA's agenda will become inevitable. Local competition between providers, who vie to contract with health plans, is largely eliminated by these consolidated systems.

Since all health care is local, the lack of competition will soon make it much harder to implement a market-based alternative to the ACA. The resulting medical monopolies will make more regulation the most obvious solution to the inevitable cost and quality problems.

To change these outcomes, I believe that Congress needs to reform the "reforms" embedded in the ACA and advanced in the recent "doc fix." This starts with removing the pervasive biases in the ACA that favor hospital ownership of medical practices. Payment reforms that create incentives for the coordinated delivery of medical care (like ACOs and payment "bundles") all turn on arrangements where a single institution owns the doctors. They're biased against less centralized engagements where independent doctors enter into contractual relationships among themselves. As the Physicians Foundation recently noted, the ACA "virtually ignored the task of renovating and strengthening medical practice."[72]

To preserve competition and market incentives that grow productivity, Congress must give independent, private-practice doctors an equal footing. The technology to enable providers to enter into more virtual collaboration is greatly improved since the original concepts around practice management failed in the 1990s.

One legislative concept worth expanding on would let a new class of "independent risk managers" act as third parties to help individual doctors analyze and share the risk of caring for these patient pools. This would make it possible for independent medical offices to band together and bid against hospitals for a pool of patients. Private companies specializing in analyzing and pricing medical risk could serve as brokers and help the doctors know what they're getting into. But for the most part, I believe the ACA deliberately crowds out this sort of market innovation in favor of hospitals and their existing networks.[73]

Individual, provider-owned medical practices also deserve equal footing when it comes to reimbursement. Right now, Medicare is paying much more for many procedures when

[72] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf
[73] Scott Gottlieb. ObamaCare's Threat to Private Practice. The Wall Street Journal, December 7, 2014. http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367

performed in a hospital outpatient clinic rather than an independently owned medical office. As I noted recently in the Wall Street Journal, things as common as heart scans ($749 versus $503), colonoscopies ($876 versus $402) and even a 15-minute doctor visit ($124 versus $70) all pay more when done by a hospital-based doctor than a privately owned medical office.

Many in Washington know that hospitals are buying doctor practices to take advantage of this difference. They have only recently expressed concerns about these differentials, and the effects. But it may be too late. The consolidation that these pay differences stoked will be hard to unwind. Right now, there is a prevailing view that favors hospital ownership of doctors and see these pay differentials as a small cost to drive that migration.

At a time when the urge is to merge doctors into hospitals and turn physicians into salaried roles, there's a private-market, counter-effort to create new models that have physicians practicing in smaller units. Many aspects of medical practice are not responsive to scale. And where scale does help -- many of the characteristics of healthcare that benefit from integration can be achieved without consolidation, by better use of new technology.

As the Physicians Foundation noted in a recent report on the topic, new practice models — from the solo "micropractice" to the patient-centered medical home to direct-pay practice — hold promise both for diversifying physicians' service offerings and for improving physician productivity.[74] Moreover, digital technologies that enable real-time claims management and payment, automate dictation and coding, and improve physicians' communication with each other and with patients could lower overhead costs and enable more efficient practice. Medical practice innovation holds the key to private practice being a viable alternative to salaried employment for the next generation of physicians.[75] This would create more competition, innovation, and ultimately choice and access for patients.

A legislative proposal to improve healthcare quality and manage its costs would support local competition between providers and choice for patients. Reform of the 'reforms' would seek to improve productivity, and preserve the entrepreneurship, autonomy and local provider competition that have long been the hallmark of American medical progress.

Dr. Gottlieb is a physician and resident fellow at the American Enterprise Institute. He was previously Deputy Commissioner of the Food and Drug Administration and served as a Senior Advisor to the Administrator of the Centers for Medicare and Medicaid Services. Dr. Gottlieb currently serves as a member of the Federal Health IT Advisory Committee, which advises HHS on health IT, implementation. Dr. Gottlieb consults with and invests in healthcare companies.

[74] The average hospital group size is almost 90

[75] Jeff Goldsmith. The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny. The Physicians Foundation http://www.physiciansfoundation.org/uploads/default/Future_of_Medical_Practices__Goldsmith__Final.pdf

Mr. MARINO. Thank you, Dr. Gottlieb.

Members on the dais will now begin their 5 minutes of questioning, and I recognize myself for my 5 minutes.

Mr. Pollack, I would like to begin with you, sir. There have been a number of reports of hospitals purchasing physician practices. In some cases, patients enter the same building and see the same doctor after the purchase, but the Medicare reimbursement rate for the service is significantly higher. In some instances, Obamacare increased these pricing disparities.

Are Medicare reimbursement rates driving purchases of physician practices, and do you think that will impact Medicare's solvency?

Mr. POLLACK. I think, Mr. Chairman, there are two issues here. One is the issue of physicians wanting to be part of teams and wanting to be part of group practices that deliver care in a coordinated way, and very often they are part of the hospital entity. That is certainly a trend that we are seeing. When physicians do become part of the hospital entity and they deliver services within the hospital entity, there are requirements that have to be met that they are part of that facility, as opposed to providing service in their own office or in a different site.

Hospital costs for those physicians are legitimately higher, and the Medicare rate does, in fact, reflect a higher amount. That is legitimate, in our view, because the regulatory requirements for practice in that setting are very different than what the requirements are in a physician office or an ambulatory care center. The patients we take care of in that setting are anyone who walks through the door, Medicare or Medicaid. We are open 24 hours, 7 days a week. The patients that are taken care of in those hospital-based physician clinics tend to be sicker, and we have studies that we are happy to submit for the record that show they are poorer and more economically challenged. They suffer from a more difficult set of circumstances. So it is, in fact, more expensive to take care of patients in those types of settings.

Mr. MARINO. Thank you.

Dr. McAneny, would you like to respond to my question?

Dr. MCANENY. Yes. Thank you very much, Mr. Chairman. I take care of cancer patients in a very poor community in New Mexico which ranks at the lowest for income. While the American Medical Association supports the right of physicians to choose employment, we focus on the word "choose." We don't believe that competition should force physicians to select employment over self-employment or other options.

I do disagree with the statement that we are unable to take care of sicker patients in the outpatient arena. In our practice, if I sold to the hospital tomorrow and I saw the same patient and did the same services, you are absolutely correct, my services would be reimbursed at a higher level if I were hospital-based than physician fee schedule. But we do take care of very ill patients, and we manage to keep them in the outpatient arena.

The regulatory burden that physicians have is one of the impediments to physician practices. The ability to be able to comply with all the regulatory requirements is one of the barriers that has driven younger physicians in particular to wanting to join hospitals in

hopes that someone else will take care of all that and just let me see my patients.

Mr. MARINO. Thank you.

Dr. Gottlieb, I have a specific question for you. In your testimony, you stated that there has been a net loss of insurers since the enactment of Obamacare. You also discuss co-op insurance plans that have been subsidized under Obamacare. Can you discuss the success rate of the co-op insurance plans and how the declining number of insurers will affect competition in the insurer marketplace? You have about 56 seconds.

Dr. GOTTLIEB. I am referring mostly to the commercial marketplace. There has been no new net commercial insurance company formation since the enactment of Obamacare, actually since 2008. So whatever new plans we have seen, new carriers enter the market, we have seen offsetting losses. And actually, we have seen a loss of new carriers. We have seen new plans enter the market, but they have all been existing carriers that have decided to offer plans on the exchanges. They are not new carriers. So I don't think that is very robust competition. It is an indication that investors aren't allocating capital to start new health plans, I think because of the regulatory impediments and the high cost of getting into the market.

As far as the co-ops and the provider-sponsored plans, particularly the hospital-sponsored plans, I think the Administration envisions that picking up the slack and providing competition. But the co-ops are all—I think almost all under water, and one has already declared bankruptcy, and I am not very optimistic that a lot of the provider-sponsored health plans are going to survive. We have done this in the past, and it has been demonstrated that hospitals don't manage risk well. There is a reason why insurance companies exist.

Mr. MARINO. Thank you.

My time has expired.

The Chair recognizes the Ranking Member, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Gottlieb, do you disagree with all of the studies that have proven that the cost of health care insurance premiums, the increases in the cost of insurance premiums has gone down since the onset of the Affordable Care Act?

Dr. GOTTLIEB. What I see is that——

Mr. JOHNSON. Do you agree or disagree?

Dr. GOTTLIEB. I disagree with the premise because what I am seeing is that costs are being shifted to consumers. So the cost of providing coverage for employers, which is what the Administration often cites, has in fact been growing less quickly than in the past.

Mr. JOHNSON. My question has to do with the premium growth, the cost of premiums, the growth in the cost of premiums.

Dr. GOTTLIEB. Right. So the cost that would——

Mr. JOHNSON. Not shifting of cost to consumers. I am just talking about the cost of health care premiums and the rise in the cost of health care premiums. Do you agree that the price increases have moderated since the passage of the Affordable Care Act?

Dr. GOTTLIEB. I disagree because the cost to consumers has gone up.

Mr. JOHNSON. All right. Thank you. You just refuse to answer that question.

Well, let me ask you this. Do you——

Mr. MARINO. Just a minute. I am going to give the witness 30 seconds to respond to that.

Mr. JOHNSON. No, no. From whose time, Mr. Chairman?

Mr. MARINO. From your time. You have to let the witness——

Mr. JOHNSON. No, no, no, no.

Mr. MARINO. You must let the witness answer the question.

Mr. JOHNSON. Mr. Chairman, the witness has not answered the question.

Mr. MARINO. Dr. Gottlieb, please respond if you would like to respond.

Mr. JOHNSON. I have a problem with parliamentary order. Parliamentary inquiry, Mr. Chairman.

Mr. MARINO. Yes?

Mr. JOHNSON. Who controls the time during my questioning of my witnesses?

Mr. MARINO. I do.

Mr. Gottlieb, answer the question.

Mr. JOHNSON. All right. Well, I am going to take exception.

Mr. MARINO. Exception noted.

Dr. Gottlieb, you may go ahead and answer the question.

Mr. JOHNSON. In fact, I am just going to—if you won't——

Mr. MARINO. No, you have to give the witness an opportunity to answer the question.

Mr. JOHNSON. Mr. Chairman, when I ask a question and the witness refuses to answer the question——

Mr. MARINO. You didn't give him an opportunity to answer the question. You kept cutting him off.

Mr. JOHNSON. The witness refused to answer the question, and it is my prerogative, Mr. Chairman, as the questioner, to——

Mr. MARINO. You still have your time, you still have your time.

Mr. JOHNSON. My time is running because I am responding to your interruption of my questions.

Mr. MARINO. You continue to ask your questions, and we will give him 30 seconds when you are——

Mr. JOHNSON. Mr. Chairman, you started at 4 minutes and 20 seconds—I had 4 minutes and 20 seconds——

Mr. MARINO. Go ahead.

Mr. JOHNSON [continuing]. When you interrupted me to try to give this witness an opportunity to answer my question in the way that he wanted to answer it.

Mr. MARINO. You have the extra time. Go ahead again with your questions.

Mr. JOHNSON. Okay. All right.

Now, Dr. Gottlieb, I asked you a question, do you agree or disagree with the studies that have shown that the rise in premium costs has been moderated since the passage of the Affordable Care Act, and you went into a discussion about shifting of costs to consumers. That is not my question. I will give you one last chance

to answer my question, and I think you understand my question. Do you agree or disagree with those studies?

Dr. GOTTLIEB. I disagree with those studies because I think they are flawed.

Mr. JOHNSON. All right. Thank you. All right.

Now, Dr. Gottlieb, do you agree that Congress should repeal the McCarran-Ferguson Act antitrust exemptions for insurance companies?

Dr. GOTTLIEB. No, I do not.

Mr. JOHNSON. All right. Thank you.

Dr. McAneny, I hope I pronounced that correctly. In a speech in June of 2015, FTC Commissioner Julie Brill stated that while the antitrust agencies are watchful of anticompetitive behavior, not one accountable care organization has been challenged for anticompetitive conduct by the antitrust agencies. What is your response to this approach to provider collaborations in the health care marketplace?

Dr. MCANENY. I think the antitrust laws are very confusing to people, with or without an affordable care organization, to try to create an organization that allows us to collaborate as physicians, take economic risk together, and to do clinical integration. And I can't speak as a physician since I am not a lawyer to what the FTC and DOJ are doing with that, but we feel that if we could release some of those barriers and make those laws much more clear so that physicians could understand them and stay within the confines of the law but still be able to collaborate together, we wouldn't have to become employees or consolidate the industry in order to create a lot of new mechanisms that could deliver better care at a lower cost.

Mr. JOHNSON. Thank you. In your written testimony you argue that Medicare and Medicare Advantage are distinct product markets. Why is Medicare not an adequate substitute for Medicare Advantage, and what effect would consolidation in the Medicare Advantage market have on physicians and seniors?

Dr. MCANENY. Thank you, sir, for that question. The AMA has found that very few patients will switch back and forth from Medicare Advantage programs to plain fee-for-service Medicare, in part because of the concerns of being able to pay the 20 percent co-pay with fee-for-service Medicare. The Medicare Advantage programs have been given extra money to be able to provide better benefits, and patients respond to that.

What we find is that when those patients consolidate into fewer and fewer Medicare Advantage plans, that if the benefits are not what the patient wants, if a physician, for example, is not on the panel of that Medicare Advantage program, that they have a distinct disadvantage in being able to get care and they are often forced to pick between their primary care doctor, who is on one, and their specialist is on another, and they need both of us. So we look at the managed care Medicare Advantage market as being distinct from fee-for-service Medicare for those reasons.

Mr. JOHNSON. All right. Thank you.

Mr. Greaney, in their testimony, both Mr. Pollack and Dr. Gottlieb observed that consolidation in the health care marketplace was hastened by the ACA. What is your response to that?

Mr. GREANEY. I think that is a bit misleading. Surely the Affordable Care Act encourages providers to get together, to consolidate, to form efficient delivery systems, and that is certainly true. But nothing in the ACA encourages consolidation to monopolies and oligopolies. In fact, just to give you an example, your doctor probably tells you a glass of wine with dinner every night is probably a good thing, but he would counsel against two bottles of wine, and I think that is what we are talking about here. We are talking about consolidation that is excessive.

As I have said in my testimony, the Affordable Care Act is premised on having competitive units at the delivery level and at the insurance level so that the ACA relies on competition and relies on healthy enforcement of the antitrust laws. If you look to the string of victories the FTC has achieved, both in hospital markets and in challenging physician mergers, it is doing its job. So to that extent, blaming the ACA for consolidation is misleading because you would be hard pressed to find a health care economist or policy person who thought what was needed was anything but the fragmentation that we have had heretofore.

Mr. JOHNSON. Thank you, and I yield back.

Mr. MARINO. The Chair recognizes the Chairman of the full Committee, Congressman Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Dr. Gottlieb, I think you wanted to explain your answer of trends with regard to insurance premiums, and I think you should be afforded that opportunity, so I will give that to you now.

Dr. GOTTLIEB. Thank you, Congressman. What we have seen in the market and what the Administration often talks about is the cost of coverage, of providing coverage for employers to their employees and premium growth, and it is true that premium growth, at least in the recent years, has moderated, although we are seeing it accelerate quite dramatically.

But what has happened is we have seen a very dramatic shift of cost to consumers. We have seen the advent of very narrow plans, closed drug formularies, closed networks, exclusive provider organizations, and all of that has served to shift costs onto consumers. I think that that is a big component——

Mr. GOODLATTE. Things that aren't covered by the insurance, in other words?

Dr. GOTTLIEB. Exactly.

Mr. GOODLATTE. So the opposite of what is purported to be the benefit of Obamacare?

Dr. GOTTLIEB. Well, closed drug formularies in particular is a real new phenomenon in the market. The only place where we had seen closed drug formularies prior to implementation of the Affordable Care Act was in Medicare Advantage. But Medicare Advantage had the protected classes which made sure that the formularies were robust.

What is happening in the Affordable Care Act in the exchange-based plans is there are closed drug formularies where if the drug isn't on the plan's formulary, you are completely out-of-pocket and what you spend doesn't count against your deductible.

Mr. GOODLATTE. I need to take my time for other things. So what you are saying is that whether or not insurance premiums are

moderating, that doesn't necessarily mean that the overall cost to the consumer and overall cost to society——

Dr. GOTTLIEB. Exactly.

Mr. GOODLATTE [continuing]. The overall cost to taxpayers has moderated.

Dr. GOTTLIEB. It has gone up quite a bit to the consumer.

Mr. GOODLATTE. Right. Thank you.

Dr. McAneny, I may come back to Dr. Gottlieb if I have time, but he said that health system ownership of medical practices is an undesirable trend. You said that you wanted to make sure that they had choice. In a moment I will go to Mr. Pollack and give him an opportunity to respond as well. But one of the things that I see and one of the things I hear from my physicians is that they are actually in competition with the employees who are at the hospital, and it is very difficult to compete with them when there are such disparate reimbursement rates that take place in the hospital compared to what the physician may get in their private practice. What is your observation about that?

Dr. MCANENY. Well, Mr. Chairman, I think you summarized it very well, that it is very difficult for individual physicians to be able to compete with hospital-based physicians because they have the leverage that we as individuals lack to be able to negotiate with insurance companies. We find that the regulatory burden is still there in the independent market and that hospitals are able to purchase a lot of the same supplies and everything else that we need to purchase at a lower price or a subsidized price.

Mr. GOODLATTE. Mr. Pollack, I take your point with regard to the cost of operating a hospital, but I also am concerned that if we are trying to promote competition and there is only one hospital in a community, and that hospital has people providing services in this area, how do the private practitioners successfully compete with the hospital practitioners, if you will, in that kind of marketplace, and what are the trends there? I see a lot of consolidation. I think Dr. McAneny said it is already at 70 percent, perhaps, of physicians going in to work at hospitals. Where do you get the competition if they all go into the hospital and nobody is out there providing that competition?

Mr. POLLACK. I think some of the competition is among hospital systems, and I think what we have to remember here is that we have a new way of paying for a lot of care in terms of different mechanisms that require payment for taking care of people.

Mr. GOODLATTE. What if there is only one hospital in the community?

Mr. POLLACK. By the way, you made an eloquent point at the very beginning, Mr. Chairman, about how health care is a unique kind of market.

Mr. GOODLATTE. I agree with that.

Mr. POLLACK. There are 13——

Mr. GOODLATTE. But I am still not going to let you off the hook with that. We still have to find ways to compete.

Mr. POLLACK. No, no, your point is very well taken. There are 1,300 critical access hospitals in this country in areas in which there really is not competition. There are another 500 or so sole

community providers or rural referral centers. So inherently, it is hard to say that competition plays out in a very even——

Mr. GOODLATTE. Competition amongst hospitals is an important issue, and we are going to get to that as a part of this series of hearings that we are going to hold. But right now I want to talk about competition between doctors working in the hospital and doctors who are working outside the hospital. How do we promote that? How do we assure that we continue to have competition from physicians who want to practice on their own; or, from a societal standpoint, from an economic standpoint, is it important that they be outside the system and practice on their own?

Mr. POLLACK. And I think that pluralistic approach still exists today. But I think what is important to recognize is that there are a lot of physicians that want to be in practices that are group practices, whether they are on their own or whether they are employed arrangements. There are a lot of physicians in the next generation that are coming out of medical school that actually want to be a part of these groups because they don't want to take calls 24/7 and they want to be part of these teams.

Mr. GOODLATTE. Mr. Chairman, if I might, I would like to let Dr. Gottlieb answer this same question that I just asked Mr. Pollack.

Mr. MARINO. Without objection.

Dr. GOTTLIEB. What was the question?

Mr. GOODLATTE. The question is how do we assure continued competition in communities that have only one hospital system when the fact of the matter is more and more physicians go to work in the hospital and take up that competition?

Dr. GOTTLIEB. I think we don't, and I practice in one such community. I think when the hospital monopolizes most of the local physicians, it is very hard to have provider-based competition. I do believe that provisions in the Affordable Care Act have skewed the market in this direction, quite deliberately so. I think it is part of a broader political philosophy that I think, to date, hasn't been successful.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. MARINO. The Chair now recognizes the Ranking Member of the full Judiciary Committee, Congressman Conyers from Michigan.

Mr. CONYERS. Thank you, Mr. Chairman.

I welcome the witnesses, apologize for my late arrival.

I would like to start off with Professor Greaney by asking him what he has heard or observed here today that you think we ought to be most cautious about in terms of this analysis between competing aspects of providers for the Affordable Care Act.

Mr. GREANEY. Thank you, Mr. Chairman. I think several of the things that have been mentioned today——

Mr. CONYERS. Pull that mic a little closer.

Mr. GREANEY. Several of the things that have been brought up today I think are absolutely valid criticisms of the current state of the law. I think the disparate payments between site of payment really makes no sense. MedPac has put out studies showing that those payments should be adjusted appropriately. That is the kind of change where I think Congress can step in and correct preexisting law, law that preexisted the ACA, and take steps.

Chairman Conyers has been talking for many years about the McCarran-Ferguson Act. You heard Dr. McAneny's testimony about changing the fraud and abuse laws to permit and encourage greater cooperation short of mergers. There are many of those steps that can be undertaken, and I think Congress should devote its attention to those things because we have a lot of old law that is like barnacles on the hull here. There is old law that is dragging competition down, but they preceded the ACA, and Congress could and should step up to the plate and deal with them.

Mr. CONYERS. Thank you.

I wanted to yield, if he needs time, to my friend from Georgia, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. I will go back to Dr. McAneny.

You mentioned the narrowing of physician networks, which happens when insurance companies consolidate. Could you tell us a little bit more about that issue?

Dr. MCANENY. Thank you very much, Mr. Johnson, for that question. That is one of our major concerns. When a patient who has, in my field of cancer, a specific need, say a genomics test that says a certain drug is indicated, I have to be able to go to my insurance company and convince them to provide that medication or that service or that referral. The more consolidated the industry becomes, the further away it is from my individual patient, the harder it is for me to weave through the regulatory areas of the insurance company to be able to get to somebody who can approve that drug for that patient, and it often takes months.

The more burdens that——

Mr. JOHNSON. And, by the way, that is not the regulatory apparatus of the government. You are talking about the regulatory apparatus of the insurance companies.

Dr. MCANENY. Exactly, sir.

Mr. JOHNSON. All right. Proceed.

Dr. MCANENY. Yes. It gets very difficult for me to be able to advocate appropriately for my patients. When the insurance company is small and local and they need me in their network, then they will listen to me when I try to get something for a patient. If I go to a national network or I am obviously always advocating for a patient, I become a disruptive physician and I am less inclined to be included in that network because I spend more money and I am a thorn in the side of insurance companies who don't want to buy those expensive drugs and processes that Dr. Gottlieb was talking about.

So it is very intimidating to physicians. If you know in your practice that you can't do without a given payer, they know that they don't really have to pay attention to what you are requesting because you can't afford to leave.

Mr. JOHNSON. And consolidation aggravates this situation.

Dr. MCANENY. It will make it far worse. Yes, sir.

Mr. JOHNSON. All right. Well, let me ask Professor Greaney, contrary to reports that costs have gone up overall for consumers since the passage of the Affordable Care Act, a shifting of, say, premium increases to higher deductibles and co-pays and that kind of thing, what is your response to that, sir?

Mr. GREANEY. We have seen a number of studies where competition has lowered premiums, has lowered costs. The exchanges are a particularly good example where it has occurred, has had a very beneficial effect on cost. The individual markets experienced much better cost experiences, and I think the message here is that competition works.

Mr. JOHNSON. Yes, 9.4 million seniors have saved more than $15 billion on prescription drugs since the passage of the Affordable Care Act, an average of $1,598 per senior.

Mr. GREANEY. Yes.

Mr. MARINO. You can finish, sir. The gentleman's time has expired, but you can finish your point.

Mr. GREANEY. Well, I was just going to mention that one important driver of cost is whether we get new entry into markets, and there is a particularly interesting example in Arkansas. When it expanded Medicaid, Arkansas said let's have the private option, let's have private insurers cover the new Medicaid beneficiaries. What happened there? Not only did the new beneficiaries get covered, but it increased competition in the marketplace in Arkansas, so everybody benefitted, including the private market. It went from two competitors to six. So private competition can be generated, and I think states that haven't expanded Medicaid are shooting themselves in the foot in the private market as well.

Mr. CONYERS. Chairman Marino?

Mr. MARINO. Yes, sir?

Mr. CONYERS. Could I ask unanimous consent for one question additional?

Mr. MARINO. Yes, sir, without objection.

Mr. CONYERS. I thank you so much.

My last question is to Professor Greaney again, and it is about the implementation of the health insurance exchanges under the Affordable Care Act. Has it promoted competition, in your view?

Mr. GREANEY. Oh, most certainly. I think we have seen a lot of markets where there has been new entry and there has been a shakeup of the markets. But there are still plenty of markets where we haven't had much competition, new entry in exchanges, and that is why Congress is rightly concerned about the insurance mergers, because we want new entry. But if we have gone from five down to three, the most likely new entrants are going to disappear. So that is a concern on the horizon.

Mr. CONYERS. Thank you, Mr. Chairman.

Mr. MARINO. The Chair now recognizes the Congresswoman from California, Ms. Walters.

Ms. WALTERS. Thank you, Mr. Chairman.

I want to direct the question to Mr. Durham, and then give Mr. Pollack an opportunity to respond.

Mr. Durham, your testimony raises concerns about hospital consolidations. The testimony cites an analysis that claims, "Hospitals and acquisitions increased 44 percent between 2010 and 2014, with a total of 442 transactions occurring during this timeframe." Surely not all of these mergers have an anticompetitive effect, and how do we differentiate between a consolidation that increases competition and one that decreases competition?

Mr. DURHAM. A very good question, Congresswoman. I believe that is really a detailed analysis that the Department of Justice conducts. They look at data that is not publicly available and examine it at the local market. It is critical that this analysis be done in specific geographic areas to really determine the potential impact on competition.

As I mentioned in my testimony and oral statement, DOJ sees that there are circumstances where mergers can create efficiencies and enhance competition. So it really depends on what they are seeing in the local geographic market.

We are all about driving value, moving away from the antiquated fee-for-service model that pays for volume and providing value for patients, lower cost, and higher-quality care. And these mergers can certainly make that happen, particularly when two companies have different areas of expertise. One may have expertise and may have done a lot in chronic care management, while another has done more in value payment models in collaboration with providers. Bringing those two together can bring higher value to patients, and that is what we are focused on in terms of bending this cost curve.

Ms. WALTERS. Thank you.

Mr. Pollack?

Mr. POLLACK. Thank you very much for that question, I appreciate it. Mr. Durham's testimony has a litany of studies that talk about how consolidation increases prices. I think a lot of them are old. They are old data. They are incomplete. For example, there is one study that is mentioned in the testimony that looks at 12 states, but they say that they can only find a relationship in three out of the 12 states. The three states that they look at—Ohio, Georgia, and Missouri—have a lot of critical access hospitals, rural referral centers, and sole community providers, which we said inherently are a different situation.

The newer studies that we have seen from JAMA show that, in fact, we have reduced costs. We have seen other studies that show that our price growth is at historic lows, and we have studies that I would be glad to submit to the record that do not show a correlation between consolidation and price increases.

The last and very important point is that we also did a study that I would submit for the record by the Center for Health Transformation, and it looked at hospital deals, if you will, between 2007 and 2013. There were 607 in that period. That represents only 12 percent of our field. Of the 607 that occurred, all but 22 resulted in at least five hospitals still remaining after those consolidations. And of the 22 where there were less than five, if you go through the stories of each of those 22, some were to prevent a bankrupt hospital from going out of business entirely, and many were to reconfigure hospitals so they can exist to be an access point in communities that wouldn't have access to care.

So I think in the hospital world, our arrangements are focused on a different objective, which is to move to the future in terms of rationalizing the system and finding ways to preserve access where many just wouldn't exist if we didn't have these arrangements. Thank you.

Ms. WALTERS. I yield back.

Mr. MARINO. Thank you.

The Chair now recognizes the congressman from Georgia, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Greaney and Dr. Gottlieb, I have a question. I will frame the question and I would like, Mr. Greaney, if you would start; and, Dr. Gottlieb, if you would weigh in on this as well.

One, I want to thank the Chairman for holding this series of hearings that we are going to be having looking at these issues and on similar topics, but I also want to focus a little bit today on one because I want to encourage that there be a hearing on this issue in particular, the effects of PBMs on competition in the health care market and how Obamacare may have affected the competition in that area.

This summer the FTC approved CVS' acquisition of Omnicare without conducting a significant investigation into the combination of the largest long-term care pharmacy with the largest Part D PBM. The FTC's lack of action ties into other concerns I have heard from my constituents about the conduct of PBMs and their effect on competition.

Independent community pharmacists play a vital role in Northeast Georgia, where I am from, a rural community, and across the Nation, but they are being crippled many times by burdensome regulations, and also the often, at times, abusive PBM practices. My constituents and I share a concern that the way Obamacare treats the PBMs will further harm independent community pharmacists.

To that end, Mr. Greaney and Dr. Gottlieb, I would like to know, in your opinion, what can be done to ensure independent pharmacies and PBMs can compete on a level playing field? And in this post-Obamacare environment, has Obamacare really affected that? And do you feel like, aside from congressional action, in the PBM space, could the FTC be doing more in this area of PBMs and independent pharmacies, especially in the health care chain?

So, Mr. Greaney, I will start with you.

Mr. GREANEY. Well, surely I agree, Congressman, that the PBMs are like other intermediaries in health care. They play an important role in containing costs and doing the bargaining. But if their size and their market structure is concentrated, we face the same problems we face in other industries. And I think, particularly in PBMs, there was the controversial decision of the FTC to allow the Express Scripts-Medco merger years ago——

Mr. JOHNSON. Excuse me, sir. Can you pull the mic up? Thank you.

Mr. GREANEY. Sure. There was some question about the FTC's decision to let that merger go forward. At the time, the FTC was comforted by the fact that there would be new entry and smaller participants would generate more competition. The FTC has done retrospectives of its own decisions, and this might be a good time for it to do so, to look back and say how has that worked out. To the extent that their prior prediction has proven untrue, and I don't know that it has but I have heard talk that it has, maybe it would be time for a retrospective to see how the market is operating.

Mr. COLLINS. Dr. Gottlieb?

Dr. GOTTLIEB. I am less concerned, to be honest about it, about the vertical integration of PBMs trying to buy acquisitions outside their core space than the horizontal acquisitions that would increase their market concentration. The reality is we have a concentrated market of PBMs, and the Express-Medco merger would concern me more than the Omnicare acquisition because it is more of a vertical integration. What is happening is the PBMs are trying to sort of buy their way out of their current market to try to capture more margin from other market segments.

I think that this would all be less concerning if it was easier for new PBMs to get started and existing PBMs that are small to continue to grow by trying to offer focused services and differentiate themselves in the marketplace. Quite frankly, I think the health plan consolidation will make it harder for smaller PBMs to continue to grow and will potentially give more market share to some of the existing large PBMs.

Mr. COLLINS. One of the things right there that concerns me is there is a PBM market there, and we understand that, but my problem is concerning our independent pharmacies and others who are outside this who would provide a service in communities in the health care chain that are basically, because of many times the practices, small or large, are being worked out.

I wasn't going to do this but, Dr. McAneny, do you all have anything to add on that, especially from—because I have heard from physicians as well who struggle with their patients to get drugs filled in a certain area because of restrictions, especially in my area, a rural area.

Dr. MCANENY. I would agree with you as another person from a rural area, sir. What we have found in practice is that the PBMs add another barrier because of their large consolidated structure that makes it hard for us to get patients what we want, and it has driven a lot of independent pharmacies out of business, and those were the pharmacies where, when somebody needs something at midnight, you can get the pharmacist to provide the drug. When it is a large consolidated company living a thousand miles away, they are not going to open a store to get patients something in the middle of the night.

Mr. COLLINS. I am glad I am not one of the only ones that has actually been ringing this bell.

This panel is great and our time is limited. Mr. Durham, I think we have had a chance to talk about this, how we deal with this in isolation. I appreciate you being here and the challenges of rural health care in a market in which consolidation is really not an aspect because you have a dominant player and you have a lot of smaller players due to many things. Obamacare, frankly, is one of them. They are struggling right now in many markets.

So again, Chairman, great hearing. I think this is something we need to continue. Again, my folks a little bit more on that issue in the whole health care chain, along with our hospitals, because it has been effective there as well.

With that, I yield back.

Mr. MARINO. Thank you.

The Chair now recognizes the congressman from Texas, Mr. Ratcliffe.

Mr. RATCLIFFE. Thank you, Mr. Chairman.

You know, during my time in Congress, already I have had to fight to protect the 700,000 Texans that I represent from the perversely named Patient Protection and Affordable Care Act because, let me assure you, the stories that I get from my constituents certainly confirm that the law does not protect them and that it is certainly not affordable. Time permitting, I could relate to you hundreds and hundreds and hundreds of examples like constituents of mine in Paris, Texas, a business owner who has seen his monthly cost go up $300 and his deductible go up $3,000; or another constituent in Gilmore, Texas who has seen his deductible go up over $7,000 this year. And now the news is even worse because we are told that the cost of insurance plans on healthcare.gov in Texas are expected to increase by another 25 percent next year. Does that sound affordable to anyone? I don't think so. It certainly doesn't seem that way to my constituents because survey after survey show that 80 percent of them are opposed to Obamacare and want to see me help get rid of it.

And it is not just individuals. It is hospitals. The impact on hospitals in my district has been, frankly, gruesome. I have had hospitals in Gilmore and Linden and Mt. Vernon and Clarksville close in just the last 2 years alone. How do my constituents who live in those rural areas get access to life-saving care and treatment that they need? How is this improving access to my constituents?

The simple truth is that it is not, that Obamacare has reduced access, it has increased the cost of health care, and it has lowered the quality of health care in my district. So I appreciate, Mr. Chairman, you having this hearing so we can learn from these witnesses on how we can keep insurance affordable, hospitals accessible, and health care competitive under this terrible law.

So let me turn and start with you, Dr. Gottlieb. Do you believe that the heavy regulatory burden under this law is driving solo and small group practices out of the health care market?

Dr. GOTTLIEB. Well, I absolutely do. I think the ACA provisions are biased in favor of consolidation of physicians into large systems. I think the arbitrage that we talked about today between the Medicare billing system, the inpatient-outpatient billing system is certainly one. But also if you look at the payment reforms, they are all structured around the idea of doctors practicing in integrated delivery systems, but they are biased in favor of a hospital owning that delivery system. For example, there is a need for physical infrastructure of the IT system. The anti-Stark provisions don't apply unless doctors are part of those new arrangements.

I think there is a way to try to come up with policies that give an equal footing to doctors practicing independently but still practicing in an integrated way, but not requiring them to sell their practices.

The other thing we need to keep in mind is that the law also increases medical practice costs quite substantially at the same time that physician reimbursement is being held flat under Medicare and probably declining commercially. So doctors are seeing their costs go up year over year, and they are seeing their revenues stay

stagnant or decline. That is also forcing them into these arrangements.

Mr. RATCLIFFE. So, Dr. Gottlieb, what impact will this have on competition?

Dr. GOTTLIEB. My view is—and I practice in a market that has a lot of doctors, but I believe in my market competition is declining because a handful of health systems are monopolizing the local providers.

I think the bigger question before this Committee is also the issue of productivity. In these arrangements, there is no good data demonstrating that productivity actually improves among providers inside these arrangements and that medical practice itself benefits from scale. There are a lot of studies demonstrating the opposite. I am sure you could find one or two studies that demonstrate the counterpoint, but there is a body of literature now showing that productivity goes down, and that should worry us.

Mr. RATCLIFFE. Thank you, Dr. Gottlieb.

Mr. Durham, can you comment on Obamacare's impact on access to mental health services and what is the insurance industry doing about it?

Mr. DURHAM. Certainly, Congressman, I would be happy to talk about that. Our industry has long supported the Mental Health Parity Act, and health plans have been committed to implementing parity requirements to ensure that patients have access to high-quality, evidence-based treatments and care at affordable prices.

Now, there is strong enforcement of parity laws, and health plan benefit and coverage options related to mental health services must be approved by state and Federal regulators. Health plan coverage decisions for mental health and substance abuse follow evidence-based guidelines and recommendations from leading medical and behavioral health specialists, and our plans are reviewing new evidence every day to make sure patients have access to safe and effective treatments.

There is still more work to be done here to address the wide variation in clinical practice and the cost of health care that pose serious barriers to patient access. We are committed to improving the value of care for all patients, particularly those that are suffering from mental problems.

Mr. RATCLIFFE. Thank you, Mr. Durham.

I see my time has expired. Mr. Chairman, I will yield back.

Mr. MARINO. Thank you.

Seeing no other Members to ask questions, this concludes today's hearing.

I want to thank all the witnesses for attending and for being present. You all contributed to answering questions that are important to us. Without objection, all Members will have 5 legislative days to submit additional written questions for the witnesses or additional materials for the record.

This hearing is adjourned.

[Whereupon, at 11:29 a.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

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September 30, 2015

The Honorable Tom Marino
Chairman
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Marino:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) would like to take this opportunity to comment on one aspect of the America's Health Insurance Plans' (AHIP) testimony for the House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law's September 10, 2015 hearing on "The State of Competition in the Health Care Marketplace."

In its testimony, AHIP cites research to support the contention there has been consolidation among hospitals and other health care providers that is directly correlated to higher-than-anticipated price hikes. The AHA has reviewed this research and found that many of the studies **rely on old data, are limited in geographic scope, or fail to look at the broader determinants of price** and, therefore, should be treated with considerable skepticism as a basis for future policy deliberations.

AHIP cited a recent study on the impact of hospital consolidation that found higher premiums in regions with high hospital consolidation.[1] Of the 12 states examined in the study, however, AHIP found only **three** instances of higher premiums, hardly enough from which to draw any strong conclusions about the relationship between hospital consolidation and premium growth. This study failed to look at other factors that might be driving premium growth, such as health insurer consolidation. In fact, another study that looked at health plans in 34 states found that the largest insurance company in each state, on average, increased their rates by 75 percent more than the smaller insurers in the same state.[2] This much larger and more conclusive study found that it was plan and not provider consolidation that was leading to higher premiums.

[1] AHIP Data Brief, Impact of Hospital Consolidation on Health Insurance Premiums, June 2015.
[2] Eugene Wang and Grace Gee, Larger Premium Increases: Health Insurer Competition Post ACA, *Technology Science*, 2105081104, August 11, 2015.

AHIP also cited a January 2015 study that it commissioned looking at the association between hospital concentration and premiums in California exchange markets.[3] This study only found a small difference in premiums of 8 percent. Again, the study was very limited in geographic scope (focused solely on California) and failed to look at insurer consolidation as a factor in premium levels.

Many studies cited by AHIP rely on old data that is not reflective of the current drivers of hospital integration, including the desire to coordinate care across the continuum, incentives to improve quality by standardizing protocols and applying best practices, payment system reform, the need for capital to invest in health information technology and pressures to achieve operational efficiencies. Furthermore, despite an increase in hospital mergers and acquisitions, hospital price growth is at the lowest level since 1998 and quality is improving.[4]

AHIP cited a June 2012 research summary by the Robert Wood Johnson Foundation.[5] The most current data used in the studies reviewed in the summary was from 2005. Even so, the literature review shows that the relationship between price and concentration is often imprecisely defined and varies widely. Whether each study finds a relationship depends on the time period under review and the specific geography covered. A more recent study conducted by the Center for Healthcare Economics and Policy used a large number of markets and much more contemporary data – 2010 through 2012.[6] **This study did not find a consistent relationship between price and concentration.**

Another study cited was a 2013 report by the Massachusetts Center for Health Information and Analysis.[7] This study claimed that higher prices were associated with organizational size. A study by Compass Lexicon that assessed a broader range of factors that might influence costs, and therefore prices, found that price differences are better explained by other factors than mergers, including case mix, teaching status, availability of specialized services and level of capital investment.[8]

AHIP also notes a research brief by the Center for Studying Health System Change that found that hospitals that can gain "must have" status command higher prices.[9] However, factors such as reputation, convenience and the availability of specialized services influence consumer preferences much more than size. In addition, some of the findings of this study are no longer true. For example, this study found that increases in provider prices are driving the increase in

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[3] Bates White Economic Consulting, ACA Exchange Premiums and Hospital Concentration in California, January 2015.
[4] Bureau of Labor Statistics, Producer Price Index data, 1998-2015 for hospitals (622), August 2015.
[5] Martin Gaynor, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, The impact of hospital consolidation-Update, June 2012.
[6] Center for Healthcare Economics and Policy, Price-Concentration: What's the Relationship? February 2014.
[7] Massachusetts Center for Health Information and Analysis, 2013 Annual Report on the Massachusetts Health Care Market, August 2013.
[8] Compass Lexicon, Assessment of Cost Trends and Price Differences for US Hospitals, March 2011.
[9] Center for Studying Health System Change, High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power, September 2013.

premiums. With hospital price growth at its lowest level since 1998, price is clearly not the driver of premium growth today.

As we noted in our testimony, hospitals are woven into the fabric of their communities, and as such, they know what their patients need and how to deliver care at lower costs while improving quality. Hospitals are responding to the enormous change that is occurring in the health care landscape by realigning in ways that promote high-quality, well-coordinated care and contribute to lower cost growth. We believe the studies AHIP cites for a contrary proposition should be treated with considerable skepticism.

Sincerely,

Richar J. Pollack
President and CEO

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November 4, 2015

The Honorable Bob Goodlatte
Chairman
Committee on the Judiciary
U.S. House of Representatives
2318 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Goodlatte:

I am writing in response to your request to address questions for the record related to my participation at the Sept. 10, 2015, hearing before the Judiciary's Subcommittee on Regulatory Reform, Commercial and Antitrust Law, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition."

Attached please find responses to questions from the subcommittee members.

If you have any questions about this information, please contact Megan Cundari, senior associate director for federal relations, at 202-626-2268 or mcundari@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and CEO

Attachments

Questions for the Record
Richard J. Pollack, President and CEO, American Hospital Association
U.S. House Judiciary Committee
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
"The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition."
September 10, 2015

In response to Subcommittee Chairman Marino's question

In your view, are there any additional factors that the antitrust enforcement agencies should take into consideration when reviewing proposed health care industry transactions, or factors that should be weighed more heavily relative to other considerations?

Answer:

For hospitals and health systems, the antitrust agencies need to appreciate that the field is undergoing a fundamental transformation, not unlike the one that led the Supreme Court to revisit conventional antitrust analysis in *United States v. General Dynamics Corporation*, 415 U.S. 486 (1974). The AHA recently submitted on amicus brief to the Supreme Court on this topic that is attached.

For commercial insurance companies, our letters to the Department of Justice's Antitrust Division (DOJ) on the Anthem and Aetna acquisitions, which were referenced in AHA's written statement and are available at http://www.aha.org/advocacy-issues/letter/2015/150805-let-acquisitions.pdf and http://www.aha.org/advocacy-issues/letter/2015/150901-let-hatton-burwell-baer.pdf, contained a comprehensive analysis of the factors that DOJ should consider in reviewing the transactions.

In response to Representative Doug Collins's question

Northeast Georgia, which I represent, has some very rural areas, and I know there are big challenges in rural health care. What do you think are the biggest challenges facing rural health care systems and how can we encourage greater competition in the rural health care marketplace?

Answer:

Approximately 51 million Americans live in rural areas and depend on their community hospital as an important – and often the only – source of health care. These hospitals face a unique set of challenges due to their remote geographic location, small size, limited workforce, physician shortages and constrained financial resources with limited access to capital. Among their greatest

challenges is financial viability, as due to their size, modest assets and financial reserves and higher percentages of Medicare patients, small and rural hospitals disproportionately rely on government payments. A recent report by FitchRatings concluded that smaller hospitals with only a single or a few sites generally had worse financial performance than those with a larger operating base (FitchRatings, 2015 Median Ratios for Nonprofit Hospitals and Healthcare Systems, Special Report, Aug. 10, 2015). The proliferation of telehealth services may allow for some additional competition in rural areas, as many telehealth services can be provided from distant locations and do not require a local presence. The AHA produced two recent TrendWatch documents that address the opportunities and challenges related to telehealth, which are available at http://www.aha.org/research/reports/tw/15jan-tw-telehealth.pdf and http://www.aha.org/research/reports/tw/15may-tw-telehealth.pdf.

In addition, the AHA is supportive of a number of pieces of legislation introduced in the 114th Congress that would enable rural hospitals to care for their communities. These include:

- The Rural Hospital Access Act (S. 332/H.R. 663), which would permanently extend the Medicare-dependent hospitals (MDH) and enhanced low-volume adjustment programs;
- The Medicare Ambulance Access, Fraud Prevention and Reform Act (S. 377/H.R. 745), which would permanently extend the ambulance add-on payment adjustment;
- The Protecting Access to Rural Therapy Services (PARTS) Act (S. 257/ H.R.1611) to ensure that the Centers for Medicare & Medicaid Services (CMS) appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and critical access hospitals (CAHs); and
- The Critical Access Hospital Relief Act (S. 258/H.R. 169), which would remove the 96-hour physician certification requirement as a condition of payment for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

Also, the AHA recently created a task force to confirm the characteristics of vulnerable rural communities and identify strategies and federal policies to help ensure access to care in these areas.

No. 14-762

IN THE

Supreme Court of the United States

PROMEDICA HEALTH SYSTEM, INC.,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF OF *AMICUS CURIAE* AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICUS CURIAE*[1]

The American Hospital Association ("AHA") respectfully submits this brief in support of granting Petitioner ProMedica Health System Inc.'s petition for certiorari. The AHA represents nearly 5,000 hospitals, healthcare systems, and networks, as well as 40,000 individual members. AHA members are committed to a robust and competitive hospital provider market, and they are deeply affected by current market trends and changes in law and technology. The AHA has a substantial interest in the application of antitrust law to hospital mergers. Hospital mergers often foster—rather than diminish—competition, and in many cases are necessary for hospitals to deliver care effectively in a rapidly changing field.

Amicus curiae files this brief specifically to urge the Court to grant certiorari over the third question presented—regarding how lower courts should weigh evidence that a merging company in the future will likely have less competitive significance. Because of its work with hospitals nationwide, the AHA can illustrate the significant confusion in the courts surrounding this so-called "weakened competitor" doctrine. This confusion has left struggling hospitals unsure when merging remains a legal option. The

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[1] Counsel of record received timely notice of the intention to file this brief, and all parties have consented to the filing of this brief. As required by Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person other than *amicus*, its members, and its counsel made any monetary contribution intended to fund the preparation or submission of this brief.

AHA can also detail how the erosion of the "weakened competitor" doctrine—as reflected in the Sixth Circuit's decision here—leaves the viability of many small and stand-alone hospitals in jeopardy.

SUMMARY OF THE ARGUMENT

Fundamental changes in the health care sector, accelerated by the Affordable Care Act ("ACA"), have transformed the competitive landscape of the field. Due to these changes, many hospitals that are viable today—particularly small and stand-alone hospitals—may not be competitive in the future. To continue serving their communities, they look to merge with other hospitals.

The key Supreme Court precedent governing mergers by "weakened" companies in transforming industries is *United States v. General Dynamics Corporation* ("*General Dynamics*"), 415 U.S. 486 (1974). But *General Dynamics* has not been addressed by this Court for forty years, and in that time lower courts have misapplied or even ignored it.

In *General Dynamics*, this Court held that market share statistics—the exact type of evidence relied upon by the Sixth Circuit here—are not determinative of whether a merger will have anticompetitive effects. 415 U.S. at 498. Rather, lower courts must examine the particular sector, including developing and ongoing transformations in the industry, to evaluate the probable effects of a merger. *Id.* Even if a company manages to remain solvent today, its weakened future prospects may justify a merger under the Clayton Act. *See id.*; 15 U.S.C. § 18.

Now, after forty years, the Court's review is warranted for three fundamental reasons:

First, "[t]he Supreme Court has not explained or amplified its holding in *General Dynamics* to any significant degree," and consequently "[l]ower courts have read *General Dynamics* in a variety of ways." *See Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1336-37 (7th Cir. 1981). These conflicting interpretations leave both lower courts and companies guessing as to the legal regime governing potential mergers.

Second, this conflict is significant in the context of a transforming healthcare sector, making this case an ideal vehicle for certiorari. Dramatic changes in healthcare, catalyzed by the ACA and other market reforms, place significant pressure on many hospitals (especially small and stand-alone hospitals) to merge in order to remain competitive.

Lastly, the Sixth Circuit's decision erodes the *General Dynamics* doctrine, setting a precedent that must be reversed. Relegating the "weakened competitor" doctrine to a "Hail-Mary pass," as the Sixth Circuit did here (Pet. App. 28a), eliminates a critical tool for many hospitals struggling to serve their communities. Contrary to the lower court's decision, hospitals should not have to wait until they are on the edge of bankruptcy to merge. Such a rule not only does a disservice to Supreme Court precedent, but also to patients and the general public.

ARGUMENT

I. COURTS ARE IN CONFLICT AS TO THE SCOPE AND MEANING OF THE *GENERAL DYNAMICS* "WEAKENED COMPETITOR" DOCTRINE.

In the past forty years, courts have adopted varying approaches to *General Dynamics*' "weakened

competitor" analysis, including ignoring it altogether. Such conflicting approaches demonstrate the need for this Court's review.

A. Under *General Dynamics*, Courts Are Required to Consider Whether Market Changes Will Weaken a Firm's Ability to Compete in the Future.

Merger analysis under the Clayton Act is forward-looking and "necessarily predictive." U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines § 1.0 (Aug. 19, 2010). Section 7 of the Clayton Act restricts acquisitions when "the effect . . . may be to substantially lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Thus, the Clayton Act "requires a prognosis of the *probable future effect* of the merger," *Brown Shoe Co. v. Unites States*, 370 U.S. 294, 332 (1962) (emphasis added), and courts look to compare the future competitive significance of a company if a merger proceeds "to what will likely happen if it does not." Horizontal Merger Guidelines, *supra* § 1.0.

In *General Dynamics*, the Supreme Court reemphasized the forward-looking nature of antitrust analysis when it focused on the future prospects of a company in the rapidly changing coal industry. 415 U.S. at 501. "[F]undamental changes in the structure of the market for coal" due to industry trends and governmental regulations placed "pressures on the coal industry in all parts of the country." *Id.* at 501-506. Thus, in evaluating the merger of two coal companies, the Court discounted current market share statistics. *Id.* "Such evidence" of fundamental change, the Court concluded, "went directly to the question of whether future lessening

of competition was probable." *Id.* at 506. Even though evidence of "past production" suggested that the acquired company was healthy and strong, evidence of industry transformation led the Court to conclude that there was no antitrust violation. *Id.*

Accordingly, under *General Dynamics*' "weakened competitor" doctrine, courts must recognize that "[s]tatistics concerning market share and concentration" based on past performance do not always paint a "proper picture of a company's future ability to compete," and "[are] not conclusive indicators of anticompetitive effects." *Id.* at 498, 501. "[O]nly a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *Id.* at 498; *see also United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975) (holding that "market-share statistics gave an inaccurate account of the acquisitions' probable effects on competition").

Crucially, *General Dynamics* distinguished between its analysis of likely future "weakened" competitors and the wholly separate "failing company" defense, applicable to companies on the brink of collapse. 415 U.S. at 506-07. This Court recognized that even if a company is not teetering on the verge of bankruptcy, "it still may not have a future ability to compete" because of recent or ongoing changes in the structure of a given market. The "failing company defense" is thus "inapposite" to whether a merger can be justified based on a company's likely future "weak competitive status." *Id.* at 508; *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

B. Lower Court Decisions Reflect Confusion As to How to Apply *General Dynamics*.

Since *General Dynamics*, lower courts have struggled to integrate its holding into their antitrust analyses. One court summarized just a few of the questions arising after *General Dynamics*:

> how wide-ranging an examination should a court or commission conduct or permit in such a showing [of a company's future weakened competitiveness] and how much weight should a court or commission give to those factors revealed by such an examination when it decides if the statistics are an inaccurate indicator of future competitive conditions.

Kaiser, 652 F.2d at 1336. Lower courts also must grapple with how "weakened" a company must be (or will be) to fall within the *General Dynamics* analysis, and how certain it is that a company will fall to such weakened status in the future. Courts must determine which evidence is suitable to make such showings, and they must then discern how to weigh such evidence against current market share statistics.

After forty years without this Court's clarification, it is perhaps unsurprising that "[l]ower courts have read *General Dynamics* in a variety of ways." *Id.* at 1337; *see also FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164-65 (9th Cir. 1984) (per curiam) (recognizing that courts have given differing "weight to a defense of financial

plight as a ground for justifying a merger"). Lower courts interpret and apply *General Dynamics* in one of two conflicting ways.

On one hand, in light of *General Dynamics*, some courts have incorporated analysis of "the particular market" and the "weakened financial condition" of a merging company into their examination of whether a proposed acquisition threatens a "substantial lessening of competition." *United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1977). These courts essentially ask whether, given the financial condition of the firm and transformations in the industry, a company could "compete effectively" if it remained in the market. *Id.* at 774-75; *see also Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276-77 (7th Cir. 1981) (holding no antitrust violation where firm's "deteriorating market position prior to the acquisition" showed that the firm "was not about to collapse," but was "anything but healthy"); *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 699-701 (8th Cir. 1979) (noting changes in industry made it probable that grocery chain would leave relevant region). If not, a merger survives antitrust scrutiny even when current market statistics might indicate otherwise.

By contrast, other courts will not even consider the *General Dynamics* doctrine except in the most extreme cases. These courts consider the *General Dynamics* doctrine the "weakest ground of all for justifying a merger." *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1221 (11th Cir. 1991). They "credit such a defense only in rare cases when the defendant makes a substantial showing that the acquired firm's weakness" (1) cannot be resolved by any competitive means (such as merger with a different company);

and (2) would cause the firm's market share to reduce to a level that would undermine the government's prima facie case that the merger would be anticompetitive based on past and current conditions. *Id.*; *see also Warner*, 742 F.2d at 1164-65 (finding reasons for "rejecting or attaching little weight" to "weakened competitor" doctrine, and holding that a company's "financial weakness does not in itself justify a merger."). By requiring such a strong showing that a company is *currently* uncompetitive, these courts have eviscerated a core principle articulated in *General Dynamics*—that antitrust law must evaluate the likely future (not current) competitiveness of a merging company.

In the instant case, for example, the Sixth Circuit deemed the "weakened competitor" doctrine the "Hail-Mary pass of presumptively doomed mergers." (Pet. App. 28a.) It stated that it would "'credit such a defense only in rare cases'" when the acquired firm's weakness, "'which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie case*.'" (*Id.* (quoting *Univ. Health*, 938 F.2d at 1221).)

Based on its poor financial condition and changing market pressures, St. Luke's argued below that it was not (and would not be) a meaningful constraint on its competitors. The Sixth Circuit held that this argument had "no basis," but it evaluated St. Luke's difficulties only "*before* the merger" without looking at St. Luke's future prospects. (*Id.* (emphasis added).) The Sixth Circuit emphasized that St. Luke's had "sufficient cash reserves to pay all of its [current] obligations," but dismissed

significant evidence of St. Luke's likely future decline. (*Id.*) Absent from its decision is any discussion of the changing nature of the healthcare sector, and whether St. Luke's would have the capital to make the necessary changes to remain competitive.

Given this line of cases, some commentators have deemed the "weakened competitor" doctrine all but moribund. Tellingly, a recent article published by the Assistant Director of the Bureau of Competition at the FTC and a former Senior Trial Counsel in the same division described the *General Dynamics* doctrine as so "highly disfavored by courts and rarely successful" that it is essentially a nonissue in judicial proceedings. Jeffrey H. Perry & Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, 27-SPG Antitrust 42 (Spring, 2013). By their reading, the "weakened competitor" doctrine "only saves a transaction in the rare scenario in which the acquired firm is so weak that its market share would soon decline and bring the merger below the Merger Guidelines and case law concentration thresholds." *Id.* This is a "high bar for defendants," requiring them to show that they are (if not actually failing) only a breath away from failing. *Id.* In essence, *General Dynamics* is—to many courts—only a "lite" version of the failing competitor affirmative defense. *See id.*

By granting certiorari, the Court can bring clarity to the *General Dynamics* doctrine, which, though recognized by some courts, teeters on the edge of irrelevancy in others.

II. THE "WEAKENED COMPETITOR" DOCTRINE IS ESPECIALLY CRUCIAL FOR HOSPITALS GIVEN THE CURRENT HEALTHCARE TRANSFORMATION.

This case provides an ideal vehicle for clarifying *General Dynamics* because the doctrine is critical in rapidly changing sectors. It is undisputed that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed." Moody's Investors Serv., *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, 7 (Jan. 25, 2012) (hereinafter *Moody's 2012 Outlook*). The ACA, along with other statutes, regulations, and sector reforms, is placing new pressures on hospitals, especially smaller and stand-alone hospitals.

Specifically, the combined pressures of (1) changing hospital reimbursement rates and methods that *reduce revenue*; (2) the need for extremely expensive electronic medical records that *increase costs*; and (3) the limited availability of capital for needed improvements to *finance change* together mean that hospitals must find new ways to increase quality while cutting costs, lest they follow a well-recognized "downward spiral" to collapse. *See* Moody's Investors Service, *2015-Outlook – US Not-for-Profit Healthcare: Cash Flow Settling into Low Level of Growth Amid Negative Outlook*, 1 (Dec. 2, 2014) (hereinafter *Moody's Outlook 2015*).

Simply cutting costs one year will not keep struggling hospitals competitive in the face of these mounting pressures. Hospitals must create economies of scale and gain access to capital. To do so, many have looked to mergers as the only means

to remain competitive. As a result, there is a major realignment occurring in the healthcare field that has generated an unprecedented number of merger challenges and "more litigated antitrust merger cases than any other segment of our economy." Moody's Investors Serv., *New Forces Driving Rise for Not-for-Profit Hospital Consolidation*, 1 (Mar. 8, 2012) (hereinafter *Moody's Consolidation Report*); Perry & Cunningham, *supra* at 42. Given the continued transformation of the health care sector, "hospital merger activity appears likely to continue unabated in the foreseeable future." Perry & Cunningham, *supra* at 42.

Accordingly, granting certiorari here would have widespread impact on struggling healthcare providers seeking to stay viable and serve local communities in a drastically changing landscape.

A. The Healthcare Sector Is Undergoing a Fundamental Transformation that Threatens the Future Viability of Many Hospitals.

1. Hospitals Face Changing Reimbursement Methods that Constrain Revenue.

Declining reimbursements have resulted in an "unprecedented threat to revenues," challenging many hospitals' financial health more dramatically than at any other time in decades. *Moody's 2012 Outlook*, at 2; *see also* Moody's Investors Serv., *Hospital Revenues in Critical Condition; Downgrades May Follow*, 2 (Aug. 10, 2011) (hereinafter *Moody's Downgrades*) ("median hospital revenue growth rate is the lowest in two decades"); Reed Abelson, *Nonprofit Hospitals' 2013 Revenue Lowest Since*

Recession, Report Says, N.Y. Times, Aug. 27, 2014, at B9 ("Nonprofit hospitals last year had their worst financial performance since the Great Recession."). The causes of reduced reimbursements are multifold.

First, hospital reimbursement rates under Medicare and Medicaid—which make up over half of hospital revenues—have been constrained and are likely to suffer even deeper cuts in coming years. *Moody's Downgrades*, at 3-4; *see also* Abelson, *supra* ("Hospitals also saw lower Medicare payments as a result of the across–the–board federal budget cuts enacted last year and other moves to cut costs.").

Beyond general rate reductions, several recent regulations that change how Medicare and Medicaid reimbursements are calculated (or penalize hospitals in certain circumstances) mean that many hospitals have recently seen, or will soon see, their revenues drop. These adjustments are not one-time cuts, but *are designed to force* structural changes that will have long-term future impact. Among these changes, just three are:

- "Two Midnight" Rule—Medicare's "two midnight" rule (effective October 2013) means that many hospital visits that do not last "two midnights" are deemed "outpatient" when they used to be reimbursed at higher "inpatient" rates. *Moody's Outlook 2015*, at 4. As a result, expected "revenue growth is lower, even though actual patient volume is unchanged." *Id.* "Smaller community hospitals" are disproportionately impacted by this rule, because they have "low average lengths of stay" that are now reimbursed at lower rates under the new rule. Moody's

Investors Serv., *Two-Midnight Rule Will Reduce Revenue for Most Hospitals*, 1 (Mar. 12, 2014) (estimating that rule will reduce revenue averaging $3000 to $4000 per case).

- Readmission Penalties—For Medicare reimbursement, hospitals now face financial penalties for having disproportionately high readmission rates. These penalties can cost a hospital up to three percent of its total Medicare reimbursements. *See* 42 U.S.C. § 1395ww(q); Jordan Rau, *Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties* (Kaiser Health News, Oct. 2, 2014). These penalties will particularly hurt those struggling hospitals without the capital to implement changes to reduce readmissions. (*See* Part 3 *infra*.)
- Reductions in Medicaid Disproportionate Share Hospital ("DSH") Payments—Starting October 2016, and extending through 2023, hospitals will face deep cuts in Medicaid DSH payments. DSH payments provide assistance to hospitals caring for a high number of Medicaid and uninsured patients. Martin D. Arrick, et al., *U.S. Not-For-Profit Health Care Outlook Remains Negative Despite a Glimmer of Relief,* 7 (S&P RatingsDirect, Dec. 17, 2014) (hereinafter *S&P 2015 Outlook*); J. Kevin K. Holloran, et al., *The Outlook for U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures*, 6 (S&P Capital IQ, Dec. 10, 2013) (hereinafter *S&P Increasing Pressures*); 42 U.S.C. § 1396r-4(f)(7)(A)(ii). Congress cut billions of dollars in DSH payments as part of the ACA, assuming that

> more people would be insured through the Medicaid expansion, and hence DSH payments would be less necessary. Andy Miller, *Economic Changes Hurt the Bottom Line for Rural Ga. Hospitals* (Kaiser Health News, Mar. 27, 2013). Many States, however, decided not to expand Medicaid. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604-05 (2012). Especially in states that elected not to expand Medicaid coverage, and for hospitals that have a high percentage of uninsured patients, DSH cuts leave a "significant gap to bridge." *S&P 2015 Outlook*, at 7.

Second, the shift from "volume"-based to "value"-based reimbursement methods threatens to reduce revenues significantly for hospitals unable to make fundamental structural and clinical accommodations necessary to reduce costs and improve quality. Both government and private insurers are moving to reimbursement models that compensate providers based on patient *outcomes* (i.e., value), not for the volume of services provided. As is oft-noted, "[o]f the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value." Healthcare Fin. Mgmt. Ass'n, *Value in Health Care: Current State and Future Directions* 1 (June 2011) (hereinafter *Value in Health Care*).

Because under this model hospitals are not compensated based on each service provided, they must improve patient outcomes or face drastic reductions in revenue. *S&P Increasing Pressures*, at 8 (volume-to-value "paradigm shift" requires

hospitals to "accept and manage greater risk"). Moreover, to comply with new performance standards, providers must have information technology ("IT") (described *infra*) that permits them to "[a]ccurately and consistently report data on appropriate metrics," share information throughout the organization, implement clinical protocols to promote consistent practices, and measure quality results against benchmarks to monitor progress. *Value in Healthcare*, at 16. Unsurprisingly, then, this "[s]hift away from fee for service" is regularly cited as a key transformation that is squeezing many hospitals. *See, e.g.*, *S&P 2015 Outlook*, at 5.

2. Hospitals Must Spend Significant Capital on Costly Electronic Health Records Systems to Remain Competitive.

A second transformation in the healthcare field is the movement toward electronic health records, which represents a significant (and often prohibitively expensive) cost to hospitals. Electronic health records can make health care delivery more efficient, cost-effective, and safe. *See* Frederick A. Hessler, *The Capital Challenge in Managing the Transition*, H&HN Magazine, 11 (2012). And they are essential to succeed in the value-based reimbursement model, as described above. Consequently, hospitals' ability to make these investments in electronic records is an important measure of their future ability to compete. *See Moody's 2012 Outlook*, at 12 ("[i]ncreased need for capital relating to plant modernization and IT systems" is one of top reasons for negative outlook for hospitals).

Additionally, a portion of Medicare and Medicaid reimbursements is now conditioned on hospitals' adoption of electronic health records. Under new regulations, every hospital is expected to meet new standards for having and using electronic medical records for its patients. *See S&P 2015 Outlook*, at 12. Initially, these federal requirements encourage hospitals to utilize electronic records in a way that promotes efficiency and quality by awarding "incentive payments" to hospitals that meet standards of "meaningful use." *Id.*; 42 U.S.C. § 1395ww(n). For example, one "meaningful use" standard requires hospitals to implement certified technology that, *inter alia*, can conduct drug-drug and drug-allergy interaction checks. 42 C.F.R. § 495.6(f)(2). However, hospitals that do not meet this and other "meaningful use" requirements will face penalties starting in 2015. *See S&P 2015 Outlook*, at 12.

Despite this imperative, hospitals' overall rate of electronic health record adoption remains low because of the large upfront costs of implementing electronic records. Michael Lasalandra, *Impact of Electronic Medical Records Discussed*, Harvard Public Health NOW (Oct. 30, 2009) (estimating that implementing electronic health records will cost between $20 and $200 million, depending on the size of the hospital). "Many hospitals have struggled with implementation and the high cost of keeping information technology systems current including capital and training costs." *S&P 2015 Outlook*, at 12.

As a result, many smaller and stand-alone hospitals struggle to keep up. *See* Catherine M. DesRoches, et al., *Small, Nonteaching, and Rural*

Hospitals Continue to be Slow in Adopting Electronic Health Record Sys., Health Affairs 4 (May 2012). If they cannot adopt electronic records, the consequences snowball over time. *S&P 2015 Outlook*, at 12. Large, system-based hospitals that are more able to afford electronic records will reap the eventual cost-saving benefits. But cash-strapped, smaller, independent hospitals will miss these benefits and instead be saddled with "meaningful use" penalties, leaving them further and further behind. *See id.*

3. Many Hospitals Face a Capital Crisis.

Although hospitals' need for capital is greater now than ever, many hospitals face structural difficulties in accessing the capital they need to adopt sophisticated IT (including electronic health records) and compete in the healthcare field. As the Administrative Law Judge ("ALJ") recognized in this case, hospitals are very "capital intensive" and to "avoid decline" they "must maintain their equipment" and "provide new systems." (Pet. App. 380a-81a.)

Yet, hospitals face great difficulty in accessing capital in today's market. Given the negative financial outlook, hospitals have faced credit downgrades, and the Standard & Poor's Ratings Services expects downgrades will continue to "outpace upgrades." Margaret E. McNamara, et al., *U.S. Not-for-Profit Health Care Stand-Alone Ratios: Operating Margin Pressure Signals More Stress Ahead,* 2 (S&P RatingsDirect, Aug. 13, 2014) (hereinafter *S&P More Stress Ahead*). Smaller, stand-alone hospitals have an even more difficult time accessing credit. *See Moody's Consolidation*

Report, at 2 ("Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."); Beth Kutscher, *S&P: Expect More Not-for-profit Hospital Mergers and Acquisitions*, Modern Healthcare (Oct. 21, 2014) ("Credit-rating agencies . . . set[] a higher bar for stand-alone hospitals to achieve the same rating as multihospital systems.").

With the capital crisis, hospitals have been forced to scale back their projects. For instance, "[i]n order to preserve liquidity, some healthcare systems delayed major projects that were not already started, halted projects already begun, postponed new equipment purchases and/or re-prioritized projects." *Moody's 2012 Outlook*, at 14. Delaying or eliminating improvement projects, however, only contributes to future decline. Without new investment, hospitals cannot improve quality (necessary for value-based reimbursement), and also may face governmental penalties. "Given the pace of change in the industry," then, "hospitals may not be able to rein in capital expenditures and remain competitive." Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals*, 5-6 (May 16, 2012). Hence, hospitals facing a capital crisis, though afloat today, may not be able to compete in the future absent a partner "to help them invest in these areas." *Id.* at 6.

4. Because of the New Pressures in Healthcare, Struggling Hospitals Face a "Downward Spiral," Threatening Their Ability to Continue to Serve Community Needs.

Together, the transformations in the healthcare field create a "downward spiral" for many hospitals. Healthcare Fin. Mgmt. Ass'n, *How are Hospitals Financing the Future?: Capital Spending in Health Care Today*, 2 (Jan. 2004). The spiral follows this sequence:

1. "Hospitals increasingly struggle with their financial health." *Id.* Due to changes in reimbursement rates and methods (to which they are unable to adapt because of insufficient capital to adopt electronic records and make other improvements to increase cost-efficiency) hospital revenues decline.
2. "[D]eteriorating financial health makes [hospitals] less creditworthy. . . [and] their ability to access capital becomes limited." *Id.*
3. Thus, hospitals "must devote a larger portion of their capital to keeping up with current demands" and "are decreasingly able to invest in the future." *Id.*
4. The result is that their "financial health drops significantly." *Id.*

As the Standard and Poor's Rating Services summarizes: "many providers will not be able to adapt" to new pressures, so they will see "ongoing

operating margin and cash flow erosion lead to [credit] rating deterioration" and an inability to stop the decline. *S&P 2015 Outlook*, at 2.

As "[s]truggling hospitals" experience this "very slow and downward spiral," they become "unable to meet consumer and competitive needs." Healthcare Fin. Mgmt. Ass'n, *Financing the Future II, Report 6; The Outlook for Capital Access and Spending*, 14 (Aug. 2006). The outlook can be especially bleak for smaller hospitals that enter the spiral with lower credit ratings and less access to capital. "[E]ventually, if they are not acquired, they wind down and close." *Id.* The results are devastating for both patients and the community.

B. Mergers Are Critical to the Future Ability of Many Hospitals to Compete as the Healthcare Field Changes.

Because hospitals "are facing mounting challenges" due to "increased industry pressures," some have sought to merge in order to maintain long-term competitive viability. *S&P More Stress Ahead*, at 2. For some, it is their only option.

Short of merging, hospitals have implemented "aggressive cost reduction strategies across the board" by, for example, cutting salaries and benefits. Moody's Investors Serv., *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, 6 (Aug. 30, 2011) (hereinafter *Moody's Medians*). But hospitals have "exhausted many of the 'low-hanging fruit' strategies to preserve margins over the last several years." *Moody's Outlook 2015*, at 3. The sustained duration of these funding challenges makes short-term cuts a mere band-aid

on a large wound. For not-for-profit and stand alone hospitals, "the sector is at a tipping point where negative forces have started to outweigh many providers' ability to implement sufficient countermeasures." *S&P More Stress Ahead*, at 2. Accordingly, hospitals that have been "successful in absorbing shocks to the system thus far through the implementation of cost savings initiatives . . . will have a more difficult time absorbing further hits to revenue." *S&P 2015 Outlook*, at 10. The "next level" and "difficult-to-achieve savings" that hospitals need to stay competitive is "increasingly unachievable" due to lack of technology or other structural barriers. *Id.* They need a partner.

Mergers often achieve two key objectives needed to survive in the transforming healthcare landscape: (1) they create economies of scale and other efficiencies, which reduce costs; and (2) they improve access to capital, which can fund IT developments and other needed projects to improve quality. Hessler, *supra* at 11.

First, "[s]ize and scale are . . . important means to gaining greater efficiencies and driving waste and costs out of the delivery systems." *Moody's Consolidation Report*, at 1. Mergers allow hospitals to gain the "size and scale" necessary to diversify revenue sources, spread costs over a larger base, seek efficiencies, and "allocate[e] . . . resources to better withstand likely future reductions in funding." Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders* (July 6, 2012). *See also* Kenneth L. Davis, *Hospital Mergers Can Lower Costs and Improve Medical Care*, Wall St. J., Sept. 15, 2014

(given sector changes, "hospitals need a large pool to survive").

Second, by merging with another hospital (or joining a hospital system) struggling hospitals can also gain greater access to capital, allowing them to make the necessary IT investments to increase quality and remain competitive in the future. Crucially, bond ratings are often tied to a hospital's size; larger hospitals tend to have higher bond ratings, in part due to their ability to gain greater efficiencies. *Moody's Medians*, at 14. Hospital mergers, therefore, have a positive impact on a hospital's credit—and its corresponding ability to access capital. The Standard & Poor's Ratings Services points to "merger and acquisition (M&A) activity [as] a significant positive for many individual credit ratings." *S&P 2015 Outlook*, at 2; Kutscher, *supra* ("Struggling hospitals and systems that otherwise would have seen their credit ratings downgraded have aligned with stronger organizations.").

Particularly for many stand-alone hospitals, merging may be the only means of achieving economies of scale and access to capital. "[G]iven the ever-growing pressures [facing stand-alone hospitals]," experts deem it "imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone." Daniel M. Grauman, et al., *Access to Capital: Implications for Hospital Consolidation,* HFM Magazine, iii (Apr. 2010). Hospitals that are "left out of consolidations, especially smaller stand-alone hospitals . . ., will face greater negative rating pressure going forward," *Moody's Consolidation*

Report, at 1, making them more susceptible to the "downward spiral."

Even the ALJ in this case recognized that hospitals such as St. Luke's, which are "struggling financially prior to [a] Joinder," may "face[] significant challenges to remaining independent in the future." (Pet. App. 541a.) "[W]hile St. Luke's was not in imminent danger of failure," the ALJ concluded that, "absent Joinder, St. Luke's future viability beyond the next several years is uncertain." (*Id.* at 539a.)

As a result, many acquisitions of stand-alone hospitals result in more competition, rather than less. As one expert explains, rather than "curtail competition, ... [h]ospital mergers are the way to promote these positive trends while delivering high-quality, better-coordinated care, improving efficiency and rooting out unnecessary costs." Davis, *supra*. Accordingly, a grant of certiorari could impact this and many other cases in the rapidly changing healthcare sector, where struggling hospitals look to mergers as a crucial tool to compete.

III. BY RELEGATING THE "WEAKENED COMPETITOR" DOCTRINE TO A "HAIL MARY," THE SIXTH CIRCUIT ELIMINATES A CRUCIAL TOOL FOR MAINTAINING COMPETITIVE HOSPITALS.

The Sixth Circuit's decision ignored both the healthcare transformation and the importance of the *General Dynamics* "weakened competitor" doctrine. It should not stand.

Given the transformation of the healthcare sector, many hospitals that are viable today will not be competitive in the future, and will eventually fail if

they are unable to merge. In general, these are not hospitals that could avail themselves of the "failing company" defense; their demise is not necessarily imminent. Yet, many hospitals in financial trouble—even if not on the brink of collapse—cannot attract capital or otherwise afford to make the investments needed to remain competitive. They may be able to make some short-term cuts, but the *structural* changes in the market mean that they need to make *structural* changes to increase quality while reducing costs. Unable to meet this new challenge, these hospitals' market share will inevitably suffer.

Because the healthcare field "continues to undergo dramatic and fundamental changes," even financial experts advise that it is "increasingly important to look beyond traditional financial statement analysis" to evaluate the strength of a healthcare company. Jeffrey Loo, *Industry Surveys, Healthcare: Facilities* 27 (S&P Capital IQ, August 2014). In short, "market realities" undermine the predictive value of past performance in evaluating the future competitiveness of many hospitals.

The Supreme Court's decision in *General Dynamics* addressed precisely this type of situation—a dynamic and rapidly changing market in which past performance was not predictive of future viability. Yet the Sixth Circuit ignored its import. The Sixth Circuit—following some other circuits—relegated a "weakened company's" reliance on *General Dynamics* to a "Hail-Mary pass." (Pet. App. 28a.) Under the Sixth Circuit's standard, *General Dynamics* is eroded such that it is no longer a meaningful part of antitrust doctrine.

Although *amicus* takes no position on whether St. Luke's merger satisfies the *General Dynamics* standard (*e.g.*, if the case were remanded), it emphasizes that the "weakened competitor" doctrine should not be eviscerated by lower courts. The law should not force hospitals to wait to merge until they are in imminent danger of closing their doors. If hospitals must tumble through the downward spiral, both patients and the community will suffer. Accordingly, the Court's consideration of the continuing importance of *General Dynamics* in our modern transforming healthcare field is essential. After forty years, the time is now.

CONCLUSION

For the reasons stated above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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November 5, 2015

The Honorable Bob Goodlatte
Chairman
Committee on the Judiciary
United States House of Representatives
6240 O'Neill Federal Office Building
Washington, DC 20024

Dear Chairman Goodlatte:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank you again for the opportunity to provide our views on competition in the health care marketplace and the consequences of market consolidation. We commend you and the Members of the Subcommittee on Regulatory Reform, Commercial and Antitrust Law for addressing these important antitrust issues.

Attached to this letter are our responses to your supplemental questions from the September 10, 2015 hearing on "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition." If you have any further questions or need additional information, please contact Lindsey Brill at (202) 789-7475 or lindsey.brill@ama-assn.org. We look forward to working with you and the Committee to ensure that our health care system remains competitive and innovative.

Sincerely,

Barbara L. McAneny, MD

Responses of the American Medical Association (AMA) to Supplemental Questions from the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law

November 5, 2015

In your view, are there any additional factors that the antitrust enforcement agencies to take into consideration when reviewing proposed healthcare industry transactions, or factors that should be weighed more heavily relative to other considerations?

There are at least three other factors that enforcement agencies could take into consideration when reviewing proposed health care industry transactions. The first factor concerns the parties' past and current reputations with the consumer community, since past and current reputation might predict future behavior. This factor could include the following kinds of inquiries:

(1) What is the reputation that each party has with respect to customer service/satisfaction, e.g., what patient complaint, grievance, or appeal histories do the parties have, and to what extent have such complaints, grievances, and appeals been successfully resolved?

(2) What is the reputation for competence, responsiveness, transparency, and professionalism that each party to the transaction has with respect to small, medium, and large employers?

A second factor could examine the parties' past and current reputation with physicians, other providers (if applicable), and other business partners. For example, if one of the parties to the transaction is a health insurer, it may be instructive to examine the insurer's reputation with physicians in terms of business and contracting practices. Relevant to this inquiry is how health plans treat local physicians, with physician retention as one indicator: are reimbursement rates below market value forcing physician practices to close, move, or sell? If one of the parties were a hospital, examining that hospital's relationship with its medical staff could provide the enforcement agencies with useful information concerning future conduct with respect to the physician community. In both cases, preexisting market dominance should be examined, with particular attention to bilateral monopolies in the form of insurer-hospital combined entities.

A final consideration could examine each party's compliance history with respect to state and federal requirements.

Each of these requirements could provide useful, but different, information. Accordingly, each factor should be given equal consideration.

More generally, the AMA believes that the antitrust enforcement agencies should take the impact of past mergers into account when reviewing proposed transactions. For example, past consolidation in the health insurance agency has been shown to result in higher premiums for consumers. Past consequences are an objective indicator of whether touted efficiencies will actually benefit consumers or outweigh anticompetitive impacts. Moreover, data from past mergers is useful in analyzing the potential effects of proposed transactions on health care quality in light of research showing a similar dynamic between reduced competition leading to higher prices and lower quality.

Northeast Georgia, which I represent, has some very rural areas, and I know there are big challenges in rural healthcare. What do you think are the biggest challenges facing rural healthcare systems and how can we encourage greater competition in the rural healthcare marketplace?

Although the rural health care system faces a number of challenges, the lack of financial resources generally and the need for additional funds to ensure patient access to physicians are the most pressing issues that need to be addressed. With respect to physician services, the AMA encourages state legislatures and Congress to develop incentives that will help recruit physicians to rural and underserved areas, and encourage physician retention. This need for recruitment and retention incentives applies both to primary care and to other specialties that are underrepresented in rural areas in order to meet communities' medical needs. Greater funding of special scholarship and loan repayment programs is one way to foster greater physician recruitment and retention, and thus preserve and expand patient access to physician services in rural healthcare markets. The AMA also supports legislation that would encourage Graduate Medical Education funding that would enable states to meet state workforce needs. Congress should retain Medicare support and federal funding for GME to protect access to care and address physician shortages in underserved areas. Additionally, more state and federal resources are needed to support and expand the overall rural healthcare system infrastructure, which includes federally qualified heath centers, critical access hospitals, area health education centers, and facilities that provide trauma and emergency care.

With respect to competition, the need for competition in rural healthcare markets is just as acute, if not more so, than in other parts of the U.S., since many rural areas are already highly concentrated, often with respect to both health insurance and provider markets. Many rural areas are dominated by two health insurers, or even by a single health insurer. Consequently, rural healthcare markets in particular have experienced a near total collapse of competition among health insurers. At the same time, rural healthcare markets are frequently highly concentrated on the provider side, e.g., frequently a single hospital or health system may dominate the provider market.

Given the lack of competition in rural areas with respect to health insurance and/or provider markets, it is imperative not only to protect whatever competition exists, but to take strong, proactive efforts to foster competitive entry. Consequently, the American Medical Association believes that the Department of Justice, the Federal Trade Commission, and state attorneys general must rigorously scrutinize any merger that could result in any reduction of health insurer competition in rural health insurance markets that are already highly concentrated. At the same time, it is essential that competition be fostered in many of the rural areas where hospital markets are already highly concentrated and noncompetitive. The AMA believes that promoting new physician-driven entry, e.g., by eliminating state certificate of need requirements, doing away with the current ban on physician-owned specialty hospital expansion and development, more flexible interpretation of antitrust requirements as they apply to physician networks, and less restrictive state and federal program integrity requirements, is a promising means of addressing concerns about hospital market concentration. Other measures such as promoting physician-led health care delivery innovation and making rural areas more attractive and viable places for physicians to practice will also help address this problem.

Response to Questions for the Record from Daniel T. Durham, Executive Vice President, Strategic Initiatives, America's Health Insurance Plans

Question Submitted for the Record from Subcommittee Chairman Marino

1. In your view, are there any additional factors that the antitrust enforcement agencies should take into consideration when reviewing proposed health care industry transactions, or factors that should be weighed more heavily relative to other considerations?

AHIP Response:
As noted in our testimony, the discussion of consolidation in the health care sector needs to begin with a clear understanding that many mergers and acquisitions are beneficial to consumers. They can be transformative, facilitate new and better products and services, and lead to efficiencies that reduce costs. The Federal Trade Commission (FTC) and the Department of Justice (DOJ), which have authority to enforce federal antitrust laws, have indicated that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products."[1]

The analysis of health insurance mergers, as with all merger analysis, will be highly fact-specific, reflecting the regulatory and market environments in which health insurers operate, in general, and in which the specific merging insurers operate, in particular. With respect to the regulatory and market environments in which health insurers operate, in general, several factors are particularly relevant to the analysis of these mergers.

First, there is no single national market for health coverage. Health insurance purchasers buy coverage in local markets, and for particular types of products, that differ widely from one another. Even the large national employers who buy coverage for employees across the country often offer their employees a range of choices from local, regional, and national plans (much as the federal government does for its employees).

Second, the total size of the merging entities alone is not a determining factor. Rather, the agencies look at potential effects in particular markets regardless of size. This is true for mergers involving hospitals, insurers, and indeed any entity in any industry.

Third, the analysis must consider the nature of the market itself and whether it is undergoing changes that are relevant to the analysis of the transaction. For example, the highly regulated nature of health insurance markets is relevant to an analysis of the potential competitive effects of transactions. Medicare Advantage plans are subject to extensive federal regulation and Medicaid plans are subject to extensive federal and state regulation. Commercial health insurance plans are highly regulated at both the national level (e.g., medical loss ratio requirements) and the local level (e.g., rate filing and rate review), with the U.S. Department of Health and Human Services and other government agencies exercising oversight over such entities. Such regulation is relevant to the analysis of health insurance mergers and distinguishes health insurance markets from many other, less regulated markets.

[1] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2010

Fourth, another relevant factor to such review is the nature of the markets themselves. Health insurance markets are in a highly dynamic period and this change is relevant to the analysis of the transactions as well. Competition within local markets is evolving with a variety of entities entering health insurance markets and expanding from one product area into another (e.g., Medicaid plans expanding into commercial markets through Exchange offerings).

Finally, any analysis of mergers must consider the potential pro-competitive effects that can be generated. In the context of health care, this might include a circumstance when an insurance entity with strength in one particular area is able to offer a better product because it is joined with an entity that offers complementary strengths. For example, a merger might join an entity with a strong track record of managing chronic conditions in the Medicare Advantage program with another entity that has strengths in meeting the health care needs of beneficiaries who are financially vulnerable through its Medicaid products. The combined entity may be able to leverage these complementary strengths to benefit all of its members. Further, the entity may be able to offer such combined competencies in innovative products on the growing Exchange markets.

In some instances, a merger may help facilitate investments in, and the implementation of, payment and delivery system reforms and streamlined quality measures, all of which support the broader use of value-based initiatives that ultimately benefit consumers.

Other important considerations include the expectation that, following a merger, economies of scale will allow fixed costs to be spread across a larger customer base and that unit costs per customer for medical care and pharmaceuticals will be lower for the merged entity, compared to what they would have been for the original two entities.

Questions Submitted for the Record from Representative Doug Collins (GA-09)

1. Northeast Georgia, which I represent, has some very rural areas, and I know there are big challenge in rural healthcare. What do you think are the biggest challenges facing rural healthcare systems and how can we encourage greater competition in the rural healthcare marketplace?

AHIP Response:

The first, and best, way to encourage greater competition in rural healthcare marketplaces is to prevent anticompetitive provider consolidation in such marketplaces. For example, mergers that reduce the number of hospitals or hospital systems from two to one or that remove the ability of providers to refer to different hospitals or systems pose a grave threat to consumer welfare. Such transactions should be challenged by federal and state antitrust agencies when they will lead to consumer harm.

Outside of the context of provider consolidation, rural areas often face a number of distinct challenges in maintaining competitive healthcare marketplaces among providers. Some of these may be geographic, such as the difficulty of going to providers outside of the area for healthcare

because of the travel times involved. Others may be demographic. For example, rural areas may have smaller population bases and therefore less ability to support some expensive types of medical equipment.

The best way to encourage greater competition in rural healthcare markets, however, is to challenge a third category of challenges – those related to regulation. For example, Certificate of Need laws have been well recognized as creating consumer harm in many instances by allowing incumbent providers to block innovative new competitors such as through outpatient centers created by local market physicians or out-of-market hospitals. Similarly, regulations that impose restrictions on telemedicine, limitations on scope of practice, and impediments to retail clinics prevent new competition that could benefit consumers.

The creation of effective new regulations can similarly improve competition in rural healthcare provider markets and benefit consumers. For example, health care provider transparency legislation can help consumers better understand the cost of care and, in conjunction with new market entry and tools offered by health plans, empower consumers to make the best choices for their care. Addressing the problem of surprise bills from out-of-network providers, in which consumers go to an in-network facility but then receive a large bill from an anesthesiologist, radiologist, or other provider who does not contract with their plan, also would benefit consumers in rural (as well as other) areas.

2. Mr. Durham, Obamacare requires that health plans comply with the Mental Health Parity Act. I have heard concerns that access to mental health care is not available through many health plans because of restrictions placed on mental health services that are not comparable to restrictions placed on other medical services, and these restrictions can impede access to care. These restrictions include prior authorizations, restrictions on formularies, reduced rates of pay for doctors practicing psychiatry, and more frequent denials of mental health care.

   In regards to proposed mergers in the insurance industry, could you discuss how consolidation in the industry will improve competition and increase access to care for mental health patients?

<u>AHIP Response</u>:

Our industry has long supported the Mental Health Parity Act, and health plans have been committed to implementing the parity requirements to ensure patients have access to high-quality, evidenced-based treatments and care at an affordable price. There is strong enforcement of the parity laws, and health plans' benefit and coverage options related to mental health services must be approved by state and federal regulators.

Health plans' coverage decisions for mental and substance abuse follow evidenced-based guidelines and recommendations from leading medical and behavioral health specialists, and our

plans are reviewing new evidence on an ongoing basis to make sure patients have access to safe, effective treatments. There is still more work to be done to address the wide variation in clinical practice and cost of health care that pose serious barriers to patient access. We are committed to improving the value of care for all patients, particularly those accessing mental health services.

Mergers among health insurers can generate numerous pro-competitive effects, including bringing mental health patients better access to affordable, high quality mental health care. For example, a merger may join an health insurer that has a particularly strong infrastructure for, and expertise in, assisting mental health patients navigate the mental health system, with its myriad touch points with pharmaceutical, therapeutic, and medical care with an entity that lacks such an infrastructure. Patients of the merged entity will benefit from broader access to such infrastructure and expertise. Finally, following a merger, economies of scale will allow fixed costs to be spread across a larger customer base and put downward pressure on unit costs per customer for mental health care-related medical care and pharmaceuticals for the merged entity, compared to what they would have been for the original two entities.

Question for the Record submitted to Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON THE JUDICIARY

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October 8, 2015

Mr. Scott Gottlieb, M.D.
Resident Fellow
American Enterprise Institute
1150 17th St NW
Washington, DC 20036

Dear Dr. Gottlieb,

The Committee on the Judiciary's Subcommittee on Regulatory Reform, Commercial and Antitrust Law held a hearing entitled "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition" on Thursday, September 10, 2015 in room 2141 of the Rayburn House Office Building. Thank you for your testimony.

Questions for the record have been submitted to the Subcommittee within five legislative days of the hearing. The questions addressed to you are attached. We would appreciate a full and complete response as it will be included in the official hearing record.

Please submit your written answers by Thursday, November 5, 2015 to Andrea Lindsey at Andrea.Lindsey@mail.house.gov or 6240 O'Neill Federal Office Building, Washington, D.C. 20024. If you have any further questions or concerns, please contact Ms. Lindsey at (202) 226-7680.

Thank you again for your participation in the hearing.

Sincerely,

Bob Goodlatte
Chairman

Enclosure

Questions submitted for the Record from Representative Doug Collins (GA-09)

1. Dr. Gottlieb, in your testimony you mention some of the potential problems with restricted networks and the negative impacts Obamacare has created here. I understand that limited access and restricted networks can be especially harmful in the drug and pharmaceutical arena. Do you agree or can you speak to that point at all?

Response to Question for the Record from Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute

Just as the Affordable Care Act popularized the use of very restrictive networks of doctors, it has also popularized the use of very restrictive drug formularies.

Many of the drug formularies offered by plans in the ACA are "closed formularies," meaning that if a medicine doesn't make it onto the narrow, preferred list; there is often no co-insurance provided. The consumer is completely on their own for paying the full costs of the drug. Moreover, whatever money they spend out of pocket may not apply against their deductibles or out of pocket limits.

Last year, to get a snapshot of how restrictive these formularies are; I looked at some of the ACA plans. I testified to these results before the House Energy and Commerce Committee and will recount them here. The findings are still relevant to the current plans. If anything, the drug formularies have grown more restrictive.

In my analysis, I examined lower cost silver health plans offered in 10 different states. For each state, I selected the most populous county in order to maximize the likelihood that I would find competitively priced insurance plans. I chose silver plans because of the availability of cost sharing subsidies (to offset the out of pocket costs) for consumers who select these options. I then looked at how the plans covered ten drugs that are widely prescribed for patients suffering from Multiple Sclerosis. I chose this disease because it is one where doctors are often reluctant to switch patients off a drug that is working, and where patients often get a different response among different drugs – so access to the full armamentarium is important.

What I found was discouraging. None of the plans provided coverage for all of the drugs; and none covered these drugs without significant cost sharing that would burden the patients with thousands of dollars of out of pocket expenses, even after they had exhausted their deductible. One plan provided partial coverage for eight of these medicines, four plans partially covered seven of the drugs, three plans provided partial coverage for six of the ten drugs, one plan only covered five, and a final plan only provided partial coverage for three of these medicines.

As I noted, under the insurance structures being widely adopted in the ACA plans, if the drug isn't on the health plan's "formulary" list, then a patient could be responsible for its full cost (with little or no co-insurance to help offset that cost). For costly specialty drugs, this can add up to substantial annual costs.

Right now, the use of closed formularies is far more prevalent in the ACA than they are in the existing commercial market. The vast majority of ACA carriers also use the same formularies across their different metal tiers within a given market. So by "buying up" to a higher metal, consumers are not getting a better benefit package in the form of a more inclusive drug formulary. In most cases, consumers are just paying higher premiums to buy down co-pays and deductible.

○