



Department of Justice

STATEMENT

OF

SHARIS A. POZEN
CHIEF OF STAFF
ANTITRUST DIVISION

BEFORE THE

SUBCOMMITTEE ON COURTS AND COMPETITION POLICY
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY"

PRESENTED ON

DECEMBER 1, 2010

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

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

When we discuss health care and antitrust, McCarran-Ferguson often enters the discussion, and it will here. The Department supports efforts to bring more competition to the health insurance marketplace that lowers costs, expands choice, and improves quality. In February, the House voted overwhelmingly, 406 to 19, in passing the Health Insurance Industry Fair Competition Act (H.R. 4626), to amend the McCarran-Ferguson Act to provide that nothing in the Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance. This Subcommittee's invaluable work—including its October 2009 hearing, for which the Antitrust Division provided testimony and other materials for the record—has been important. The Administration's Statement of Policy, strongly supporting the Health Insurance Industry Fair Competition Act, noted that health care reform should be built on a strong commitment to competition in all health care markets, including health insurance. (The Statement is available at

www.whitehouse.gov/sites/default/files/omb/legislative/sap/111/

saphr4626r_20100223.pdf.) The passage of the Health Insurance Industry Fair Competition Act, as it applies to the health insurance industry, would give American families and businesses, big and small, more control over their own health care choices by promoting greater insurance competition and outlawing anticompetitive practices like price fixing, bid rigging, and market allocation that drive up costs for all Americans.

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

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

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

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

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

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

Innovation and Efficiency in Health Care Delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enforcement

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

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

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

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

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

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

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

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

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

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

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

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

Industry Analysis

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

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

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

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

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

Competition Advocacy

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

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

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

Conclusion

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

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

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