



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**

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September 10, 2015

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STATEMENT

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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 Model⁵ 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.

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

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

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

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/spceches/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

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

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_SpecHospitals.

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

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](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.