Statement of David Balto

Before House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Hearing on

H.R. 372, the "Competitive Health Insurance Reform Act of 2017"

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Chairman Marino, Vice Chairman Farenthold and Ranking Member Cicilline and other members of the committee, I appreciate the opportunity to come before you today and testify about the McCarran-Ferguson Act. I have observed and analyzed health care competition as a government enforcer for over 15 years, as the Policy Director of the Federal Trade Commission, as a consumer advocate, and as counselor to healthcare providers, employers, and unions.[1] Where competition thrives, consumers benefit from numerous choices, low prices, superior service, and innovation. But where competition is absent, consumer pay more for less, have fewer choices, and are at the mercy of market participants with unbridled power. Bringing competition to health insurance markets is essential to achieving meaningful health care reform.

Lack of health insurance competition has led to supra-competitive profits, an epidemic of deceptive and fraudulent conduct, and escalating costs. As the Justice Department demonstrated in successfully challenging the Aetna-Humana and Anthem-Cigna mergers, concentration in health insurance markets is incredible. Today, there are only five national competitors -- UnitedHealth, Anthem, Cigna, Aetna and Humana. Local competition is often worse. For example, a recent Commonwealth Fund analysis found that 97 percent of Medicare Advantage plan markets in U.S. counties are highly concentrated.[2] According to the Kaiser Family Foundation, on average, a state's largest insurer has over a 55 percent market share, and only four insurers within a state have at least a five percent market share.[3] This is true whether you look at individual, small group, or large group markets. Alabama is by far the worst, with Blue Cross Blue Shield of Alabama controlling between 90 and 97 percent of consumers in each of these markets.[4]

Yet the health insurance industry is one of two markets (the other is baseball) that is exempt from federal antitrust laws. The McCarran-Ferguson Act, passed in 1945, effectively grants all insurers an exemption from federal antitrust or consumer protection enforcement. Many legislators, antitrust practitioners and scholars have called for its repeal over years.

H.R. 372, Competitive Health Insurance Reform Act of 2017, will amend the McCarran-Ferguson Act ("MFA") to provide that certain anticompetitive conduct by health insurers and medical malpractice insurers is not immune under the antitrust laws. The bill is a good first step to reforming health insurance markets. The ability for continued health care reform to succeed depends upon all aspects of health care markets to function effectively.

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[1] I am former policy director of the Federal Trade Commission and was actively involved in several health care matters and the revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care. In my practice I typically represent unions, employers, consumers, and providers in health care competition advocacy. A partial list of my advocacy is in Appendix A. Of greatest relevance I formed and run the Coalition to Protect Patient Choice, an advocacy group for consumers on health care competition and led the consumer opposition to the Aetna-Humana and Anthem-Cigna health insurance mergers. See www.thecppc.com.

[2] Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist?" (New York: The Commonwealth Fund, 2015), *available at* http://www.commonwealthfund.org/~/media/files/. publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

[3] Health Insurance & Managed Care Indicators: Insurance Market Competitiveness, http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

[4] *Id.*

The question before you today is whether a general antitrust exemption for the health insurance industry is necessary. The answer is simple and clear - absolutely not - and makes the following points:

- **Congress should abolish the McCarran Ferguson Act antitrust exemption. It is an anachronism that is severely out of date with contemporary antitrust law and weakens competition in health insurance markets in which the forces of competition do not function well.**

- **Antitrust exemptions are rarely used and only in very limited conditions. That is sound policy because antitrust exemptions replace the discipline of the market with private regulation.**

- **According to the bipartisan Antitrust Modernization Commission antitrust exemptions can only be justified if there is a clear case that the conduct in question would subject the actors to antitrust liability and no less restrictive way to solve the problem. The MFA exemption cannot meet these standards since antitrust law has evolved to permit the type of conduct (information sharing) that was threatened by the then-state of the law.**

- **The health insurance market is probably the worst type of market to have an antitrust exemption. It is highly concentrated, transactions are complex and opaque, and entry barriers are high. In other words, it is a fertile environment for anticompetitive conduct. That is the worst environment in which to deter the discipline of the antitrust laws and the marketplace.**

- **It would be a mistake to assume the exemption does not impose costs to competition to consumers. Exemptions invariably harm consumers by removing the discipline of the market. The law is uncertain and dominant insurers can use it to justify anticompetitive conduct such as market divisions that lead to higher prices for consumers. Moreover, it is difficult to assess the cost of an exemption since it creates an obstacle to complete antitrust scrutiny.**

- **MFA effectively defers consumer protection enforcement in the health insurance industry to the states. Yet health insurance consumer protection is sporadic at best with less than a handful of states bringing almost all the enforcement actions. This means that the Federal Trade Commission, the federal agency tasked with consumer protection, is not able to provide a high standard of uniform protection in all states. Instead, state insurance commissioners are charged with a wide variety of tasks and do not necessarily have the capacity to fully address the problems that their states' residents are experiencing.**

- **Eliminating the MFA exemption is only a first step in beginning to protect competition and reverse the competitive problems in the health insurance**

marketplace. We need a combination of strong antitrust enforcement and sound regulation to protect and foster competition in these competitively fragile markets. Fortunately, there is much stronger health insurance antitrust enforcement -- that must be continued. The DOJ's successful litigation against the proposed Aetna/Humana merger has been estimated to save consumers and taxpayers $500 million per year. And there are key reforms to the health insurance market in the ACA that Congress should consider retaining in any reform of the Act. Those include the health insurance exchanges, level playing field between insurers and consumers (consumer protections such as banning discrimination on pre-existing conditions and standardizing products), rating rules and review, and medical loss ratio regulation.

I. The McCarran-Ferguson Act is No Longer Necessary; Modern Antitrust Law Recognizes the Procompetitive Activities MFA Was Meant to Protect

There are very few exemptions to the antitrust laws and for good reasons. Antitrust exemptions remove the force of the marketplace and permit firms to replace the discipline of the market with their own decisions. In effect, private regulation replaces competition. In 2007, the bipartisan Antitrust Modernization Commission (AMC) stated that "statutory immunity from the antitrust laws should be disfavored."[5] According to the Antitrust Modernization Commission, free-market competition is the foundation of our economy, and antitrust laws stand as a "bulwark to protect free-market competition."[6] This is the reason why congress has passed exemptions in very few circumstances, and no general exemption – like MFA – since its enactment.

The AMC was "skeptical about the value and basis for many, if not most or all, of these immunities. Many are vestiges of earlier antitrust enforcement policies that were deemed to be insufficiently sensitive to the benefits of certain types of conduct. Others are fairly characterized as special interest legislation that sacrifices general consumer welfare for the benefit of a few."[7]

The AMC set a stiff burden to justify an antitrust exemption:

> Statutory immunities from the antitrust laws should be disfavored. They should be granted rarely, and only where, and for so long as, a clear case has been made that the conduct in question would subject the actors to antitrust liability and is necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general.[8]

MFA fails in both of these respects. Indeed, MFA serves the same function as bad regulation in that it shields insurance companies from healthy competition.

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[5] Report and Recommendations, Antitrust Modernization Commission (Apr. 2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.
[6] *Id.*
[7] *Id.*
[8] *Id.*

First, a few words of background. MFA was passed at a time when a large amount of cooperative conduct was declared per se illegal and it was difficult for small firms to collaborate. A Supreme Court decision in *U.S. v. South-Eastern Underwriters Ass'n*, 32 U.S. 533 (1944) effectively prevented information sharing that insurers relied on to engage in rate setting. It was feared at that time that overzealous enforcement would prevent many procompetitive activities that were seen as necessary in the industry. For example, data collection and dissemination, standard setting, and other collaboration that were considered necessary to keep down costs. Congress originally crafted MFA as a temporary moratorium to protect these procompetitive behaviors.[9] It wasn't until the bill reached the joint conference committee that the bill changed from a temporary moratorium to a permanent exemption.[10]

Since MFA was passed, antitrust law has substantially changed to recognize the need for collaboration, especially the type that the MFA was passed to protect. The conduct challenged in Southeast Underwriters would most likely be legal under the current interpretation of the antitrust laws. Horizontal agreements among competitors that may serve procompetitive goals are not automatically condemned. For example, the Supreme Court in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) refused to condemn as *per se* illegal a technical horizontal price fixing agreement, because it created a beneficial new product for the market. Since *Broadcast Music*, the Supreme Court has taken a more nuanced view of the behaviors that Congress wanted to protect with MFA, and activities like information sharing are now understood by courts to be potentially procompetitive and judged under the rule of reason.[11]

Indeed, the well-respected antitrust scholar Herbert Hovenkamp has advocated for repeal of MFA because most of the practices Congress originally intended to grant immunity are no longer violations of the antitrust laws and "to the extent that the insurer's practices are actively supervised by state regulators pursuant to a state policy to substitute regulation for market competition, the insurer would enjoy a 'state action' immunity under the Parker doctrine."[12] This second point is important, because "the presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity."[13]

Our modern antitrust laws have been struggling under the antiquated MFA. Courts have repeatedly been faced with cases of anticompetitive behaviors of the kind that Congress clearly did not intend to protect. When faced with these behaviors, these courts often go through mental gymnastics in their attempts to narrow MFA in order to protect consumer welfare. This has left a law that, unnecessary on its best day, now looks like swiss cheese. It does not take a legal scholar to understand that unclear laws are bad for the

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[9] Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 Wm. & Mary L. Rev. 81, 87-88 (1983), http://scholarship.law.wm.edu/wmlr/vol25/iss1/3.

[10] *Id.*

[11] *See* ABA Section of Antitrust Law § B.3.a., Antitrust Law Developments (7th ed. 2012).

[12] Hovenkamp, Herbert J., The Insurance Industry's Antitrust Immunity (January 23, 2010). U Iowa Legal Studies Research Paper No. 10-03. Available at SSRN: https://ssrn.com/abstract=1489594 or http://dx.doi.org/10.2139/ssrn.1489594.

[13] 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 25 (3d ed. 2006).

marketplace. The MFA that stands today is the worst kind of law - one that does nothing but bring uncertainty and confusion to the market while preventing vigorous competition by deterring enforcement.

The AMC tells us that in determining whether to adopt or keep an exemption Congress should consider "whether the conduct to which the immunity applies, or would apply, could subject actors to antitrust liability." I have practiced antitrust law for over 30 years, including at the highest level of government. I have no doubt that any of the conduct the defenders of the exemption would seek to engage in – such as historical information sharing - would be clearly permissible under current antitrust law. Antitrust scholars agree.[14] Indeed, the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care make it clear that sharing of historical cost and price information is typically precompetitive, so long as appropriate safeguards are adopted.[15]

The MFA cannot meet the standards set by the Antitrust Modernization Commission and should be abolished.

II. MFA Shields the Wrong Kind of Behavior, Leading to Anticompetitive Conduct and Inadequate Enforcement Thereof

Professor Herbert Hovenkamp has called MFA's application "perverse." MFA insulates horizontal agreements such as price fixing and forms development, where the potential for abuse is high, while discouraging potentially positive vertical agreements such as health insurance/provider agreements, where the threat to competition is low.[16] As former Assistant Attorney General for Antitrust Christine Varney noted, "The most egregious anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune from antitrust prosecution."[17] Thus the DOJ testified that MFA was "very expansive" and recommended its repeal.[18]

Horizontal conduct – agreements among competitors – is a core concern of the antitrust laws. Yet the MFA often immunizes this type of conduct.[19] For example, the Eleventh Circuit found that MFA exempts an alleged agreement among auto insurers to "lower the quality and cost of repairs by specifying the use of non-OEM parts and not passing along the savings to their

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[14] Hovenkamp, *supra* note 12.

[15] U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Policy in Health Care (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf (For example, Statement 5 states that the provision of factual information about fees charged and amounts, levels, or methods of fees or reimbursements does not necessarily raise antitrust concerns. Statement 6 states that participation in exchanges of price and cost information does not necessarily raise concerns and often has significant benefits to consumers).

[16] Hovenkamp, *supra* note 12.

[17] Statement of Christine A. Varney, Assistant Attorney General of the Antitrust Division of the U.S. Department of Justice at 3, Hearing on Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry (October 14, 2009), https://www.justice.gov/archive/atr/public/testimony/250917.pdf (citing *Id.*).

[18] *Id.*

[19] Hovenkamp states an "agreement among insurers on the policy price, terms, and conditions is exempt." Hovenkamp, *supra* note 12. This has led to several bad results where harmful activity was found to be exempt.

policyholders through reduced premiums"[20] Additionally, both the Eighth and Eleventh Circuits have found alleged price fixing agreements to set rates of insurance are exempt under MFA.[21]

Moreover, as Hovenkamp has observed, the exemption is often applied too broadly: "The presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity."

Worse, antitrust enforcement may be discouraged even where MFA does not apply. Although MFA has been narrowed, the court-created standard of when MFA immunity is triggered can be hard to apply. This confusion deters enforcers and private plaintiffs from bringing expensive antitrust actions, because there is vast uncertainty about whether they can survive a motion to dismiss based on MFA immunity. For example, the Blue Cross Blue Shield Association ("BCBSA") has often been accused of horizontally allocating markets - something almost always illegal under the antitrust laws - but it was not until just a few years ago that providers and customers actually brought suit. An MFA defense was rejected by the district court, but it was still the first hurdle plaintiffs had to clear before they could proceed.[22] Indeed, scholarship by American Antitrust Institute senior fellow Randy Stutz posited that the availability of MFA immunity was potentially a factor leading to this type of agreement.[23]

Proponents of the exemption may suggest that in many cases, the courts reject the exemption and therefore it does not harm competition. An unnecessary defense, even though it is rejected by the courts, is still harmful. In effect, even where it is rejected, it creates a pothole in the road to effective antitrust enforcement. Antitrust enforcers and private plaintiffs must still attempt to defeat the defense which will also create litigation uncertainty. Ultimately the existence of the defense increases the costs and uncertainty of litigation and thus effectively protects anticompetitive conduct. MFA is like the bad regulations President Trump ran against - serving no purpose other than to increase costs, decrease competition, and create confusion.

III. The Health Insurance Market is Competitively Fragile and is the Last Type of Market That Should Receive an Antitrust Exemption

There are three necessary components of a functioning market: choice, transparency, and a lack of conflicts of interest.[24] Consumers need meaningful alternatives to force competitors to

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[20] *Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004).

[21] *Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.) cert. denied, 492 U.S. 920 (1989) (finding an alleged price fixing agreement to set the rates of workers' compensation insurance to be exempt); *Uniforce Temporary Personnel, Inc. v. National. Council on Compensation, Inc*., 892 F. Supp. 1503 (S.D. Fla. 1995), aff'd, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rate-making organization to make temporary employee services pay higher workers' compensation rates was exempt business of insurance).

[22] In Re: Blue Cross Blue Shield Antitrust Litigation (MDL No.: 2406), No. 13-20000, Doc. 204 (N.D. Ala. filed June 18, 2014). I am one of the counsels in the provider case.

[23] Stutz, Randy, Market Allocation in the Health Insurance Industry and the McCarran-Ferguson Act (March 8, 2011). Oregon Law Review, Vol. 89, No. 3, 2011. Available at SSRN: https://ssrn.com/abstract=2202470 or http://dx.doi.org/10.2139/ssrn.2202470.

[24] Testimony of David A. Balto, "The Effects of Regulatory Neglect on Health Care Consumers" before the Senate

vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these three elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: A 2016 AMA study found over 70 percent of 388 metropolitan areas, representing all 50 states and the District of Columbia, were "highly concentrated." In 91 percent of markets, one insurer had a commercial share of 30 percent or greater and in 40 percent of the markets one insurer had a share of at least 50 percent.[25] According to the Kaiser Family Foundation, on average, a state's largest insurer has over a 55 percent market share, and only four insurers within a state have at least a five percent market share.[26] A recent Commonwealth Fund analysis found that 97 percent of Medicare Advantage plan markets in U.S. counties are highly concentrated.[27] Concentration has led to substantial premium rate increases, lower premiums paid to providers, and resulting consumer harm from reductions in service and quality of care.

Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but simply follow the lead of the price increases of the larger firms. This was clearly demonstrated in the litigation challenging the Anthem-Cigna and Aetna-Humana mergers.

Health insurance is a market that is generally plagued by competition problems, lax antitrust, and insufficient consumer protection enforcement that have led to a poorly functioning health insurance market. Few markets are as concentrated, opaque, contain such high barriers to entry, and are as conducive to deceptive and anticompetitive conduct. Congress has recognized over and over that these markets lack sufficient competition and transparency necessary for a competitive market. As a result, the health insurance market is the worst type of market to have an antitrust exemption.

Uncertain antitrust standards, and the potential to exempt illegal conduct can only worsen competition in the market, drives up costs for consumers, reduces choice, creates barriers to entry, and harms health care providers. That is the worst environment in which

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Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

[25] Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2016 update, American Medical Association, https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2780009&navAction=push#usage-tab.

[26] Health Insurance & Managed Care Indicators: Insurance Market Competitiveness, http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

[27] Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist?" (New York: The Commonwealth Fund, 2015), *available at* http://www.commonwealthfund.org/~/media/files/.publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

to eliminate the discipline of antitrust laws and the market place.

IV. MFA May Prevent Sound Consumer Protection Enforcement by the Federal Trade Commission

The McCarran-Ferguson Act makes the FTC's jurisdiction over health insurers unclear, at least with respect to consumer protection violations. This is especially important when health insurers overcharge or otherwise abuse consumers, as most state laws individuals have no private right of action under the insurance rating law or unfair insurance trade practices act. And state insurance commissioners have very limited resources to investigate consumer protection violations.

Confirming that the FTC has jurisdiction where only state insurance commissioners are now involved would benefit consumers enormously. Amending the MFA, which would make it clear that the FTC can take action against unfair or deceptive trade practices in the health insurance industry and provide strong consumer protection on the federal level is needed.

V. State Enforcement is Insufficient to Substitute for Effective Federal and Private Enforcement

Congress may have envisioned upon enacting MFA that states would be fully capable of protecting consumers from competitive harm and providing adequate consumer protection. Indeed, all states have insurance commissioners and there is also a National Association of Insurance Commissioners. But there are many reasons a system of state enforcement alone may be inadequate to effectively protect consumers from anticompetitive or deceptive practices. First, insurance commission offices have extremely limited resources. A study by the Center for American Progress found that the vast majority of enforcement actions against health insurers for consumer protection violations were taken by only five states.[28] Thirty-three states brought zero consumer protection actions. Other than that handful of states, there is sporadic enforcement action at best.

The situation on the antitrust side is no better. As this Committee knows well, antitrust cases are extremely complex, costly, and time-consuming. In the recent Anthem-Cigna and Aetna-Humana mergers, very few state insurance commissioners engaged in a careful hearings process to evaluate the merger. Less than a handful of states issued decisions evaluating the antitrust issues in the mergers. Some states, such as Florida, approved the Aetna merger, despite the DOJ and the district court finding substantial competitive problems in that state.

Moreover, according to the state insurance commission and the National Association of Attorneys General websites, there have not been any health insurance antitrust enforcement actions brought solely by state insurance commissioners or state AGs without taking the lead

[28] David Balto and Stephanie Gross, *Don't Leave It to the States*, Center for American Progress (Oct. 22, 2009), https://www.americanprogress.org/issues/healthcare/news/2009/10/22/6800/dont-leave-it-to-the-states/.

from federal enforcers in quite some time.[29]

State antitrust and consumer protection enforcement are insufficient to make up for the impediments for enforcement caused by the MFA. Indeed, the State of New York has supported repeal of MFA in the past, arguing that "[t]he exemption has interfered with the ability of public and private enforcers to readily use the full panoply of federal antitrust remedies to correct, deter and obtain compensation for abuses in the insurance sector."[30]

VI. The "Costs" of the Exemption Compel Repeal

Proponents of the exemption suggest that the sponsors of the legislation must demonstrate there are substantial costs being imposed by the exemptions. They are asking the wrong question. According to the Antitrust Modernization Commission, it is the ***proponents*** of an exemption who must demonstrate that there is market failure and that the exemption is necessary to achieve some overarching procompetitive goals. Furthermore, proponents should have to show that there is no less restrictive alternative method of achieving these procompetitive goals.[31] Since none of the conduct that the exemption proponents seek to engage in faces antitrust risk, they cannot meet that standard.

Moreover, by suggesting that the sponsors of the legislation must demonstrate the cost of the exemption, the proponents set an impossible standard. Because an antitrust exemption dampens enforcement and antitrust scrutiny, and weakens consumer protection, one typically will not know what the costs of the exemption are. Industries that are exempt are not subject to appropriate scrutiny and therefore one cannot know the cost of lost competition.

As former FTC Policy Director and Heritage Foundation Senior Fellow, Alden Abbott has explained it is often impossible to demonstrate the "but for" world – the costs of an antitrust exemption. In his testimony to the Antitrust Modernization Commission he said "[i]n attempting to assess the magnitude of harm caused by antitrust exemptions, we cannot directly examine the 'but for' world that would exist in the absence of such exemptions. Nevertheless, it is instructive to look at the positive welfare effects of deregulation in certain industries, because antitrust exemptions are like economic regulation in the sense that they, too, produce a more constrained form of competition. For example, the positive welfare effects of transportation deregulation (trucking, airlines), well documented by economists, may be a sort of 'natural experiment' that highlights the benefits that flow from introducing more vigorous competition when it previously existed in a much more constrained form."[32] A Cato Institute policy brief explains that

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[29] A search of the NAAG Antitrust Committee website, as well as state insurance commission websites did not return any results for recent enforcement actions not involving federal enforcers.

[30] Comments of the Office of the Attorney General of New York State In Response to the Request for Public Comments on Immunities and Exemptions, http://govinfo.library.unt.edu/amc/public_studies_fr28902/immunities_exemptions_pdf/Office_of_NY_AG_revd.pdf.

[31] Report and Recommendations, *supra* note 5 at 354.

[32] Alden F. Abbott, Prepared Statement Before the Antitrust Modernization Commission (Dec. 1, 2005), https://www.ftc.gov/sites/default/files/documents/public_statements/ftc-staff-testimony-antitrust-modernization-

deregulation of airlines led to more competitors, lower prices, and higher percentage of seats filled.[33]

Abbott further observed “[m]any exemptions (albeit in different ways, depending upon the statute) allow firms to agree to limit the terms of competition among themselves and impose restrictions on entry into the affected sector. To put it more bluntly, such exemptions foster legal cartels. From an antitrust perspective, such agreements – ‘horizontal restraints’ – generally present the greatest risk of competitive harm. Unless the restraint is reasonably necessary to the generation of countervailing efficiencies, consumers.”

Recognizing the problematic results of certain antitrust exemptions, Congress has eliminated antitrust exemptions in the past, even where there was not clear evidence of competitive harm.[34] We do know from some examples that where antitrust immunities or exemptions were eliminated, there were substantial consumer savings.

Even in the limited facts before us, there can be some compelling evidence that MFA leads to continuing ongoing harm. For example, Blue Cross has a national licensing scheme that prevents Blue Cross plans from competing with each other. For example, subscribers in Ranking Member Cicilline’s district who wish to choose between “Blue plans” only have the alternative of BC of Rhode Island -- BC of Massachusetts or Connecticut dare not invade Rhode Island and risk running afoul of association rules. Or in Chairman Goodlatte's district, consumers’ only Blue plan option is Blue Cross of Virginia. The BC subsidiary in Northern Virginia, Carefirst, cannot invade Richmond or vice versa. The harm caused by geographically segmenting the market could be hundreds of millions of dollars, since that type of competition can significantly lower premiums for consumers (or improve reimbursement for providers).

In private litigation, a district court has held that MFA does not immunize the conduct, however, Blue Cross is still able to use MFA as a defense in appealing the decision. We do not know what the appellate court will decide, but it’s safe to say that MFA continues to be an arrow in Blue Cross's quiver which emboldens them to fight this battle. Antitrust exemptions encourage firms to “play it close to the legal line." Therefore, there may be attendant harm even if the conduct has not blossomed into a full-blown antitrust violation.

Additionally, under previous MFA rulings it appears that insurance companies could agree to fix prices, or worse – they could agree to lower the quality of care a patient receives in order to save on costs.[35] These types of activities would be disastrous for consumers and yet

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commission-concerning-statutory-immunities-and/051202statutory.pdf.

[33] Thomas Gale Moore, Cato Institute Policy Analysis: Deregulation and Re-Regulation of Transportation, Cato Institute (Jul. 8, 1982), https://www.cato.org/publications/policy-analysis/deregulation-reregulation-transportation.

[34] See, e.g., Congressional reform to antitrust immunity enjoyed by the rail transportation industry: Railroad Revitalization and Regulatory Reform Act, Pub. L. No. 94-210, 90 Stat. 31 (1976); Staggers Rail Act, Pub. L. No. 96-448, 94 Stat. 1895 (1980); Interstate Commerce Commission Termination Act, Pub. L. No. 104-88, 109 Stat. 803 (1995).

[35] *See Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004); *Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.) cert. denied, 492 U.S. 920 (1989) (finding an alleged price fixing agreement to set the rates of workers’ compensation insurance to be exempt); *Uniforce Temporary Personnel, Inc. v. National.*

would likely go unpunished.

VII. Eliminating MFA is Not Strong Enough Alone to "Fix" Health Insurance Markets

While repeal of the McCarran-Ferguson Act is an important part of fostering real competition in the health insurance marketplace, it cannot do this work alone. The important lesson of the past decade of scrutiny of health insurance markets is that neither antitrust enforcement nor regulation alone can solve the chronic problems in health insurance markets. Rather, the market needs continued vigorous antitrust enforcement combined with smart regulations to protect consumers from the exercise of market power and attempt to overcome the chronic weaknesses in health insurance markets. In these efforts, I would urge this Congress to keep some important provisions of the Affordable Care Act that protect consumers and make health insurance markets more responsive to consumer demand. These provisions will fit hand in glove with a repeal of McCarran-Ferguson to restore health insurance markets through healthy competition. In addition, the Trump administration must continue Obama Administration's record of strong antitrust enforcement.

The importance of an overall policy to promote competition cannot be understated, as seen in the past month when two judges rejected the mega-health insurance mergers of Anthem-Cigna and Aetna-Humana, citing competitive concerns. In a climate where market power is present and only a handful of large companies dominate, these mergers would have reduced the number of major insurers from 5 to 3. For several weeks in two separate courtrooms, the public heard first hand how concentration and these mergers lead to higher premiums, less innovation and less service.

In that same vein, it must be recognized that the ACA includes essential and hard won provisions that worth preserving to promote and facilitate competition. Obviously the ACA is controversial and will receive careful scrutiny in this Congress. But let's note the successes.

The Affordable Care Act was successful in its goal of providing Americans greater access to health insurance. Over 20 million Americans have health insurance today because of the ACA and the the uninsured population has been reduced to 28.5 million.[36] 52 million cannot be denied coverage due to a pre-existing condition. People with complex or chronic conditions no longer live in fear of hitting a lifetime cap on what their health plan will pay. Women are no longer forced to pay more than men for coverage. We have also successfully bent the cost curve. The Congressional Budget Office recently adjusted its projected spending on Medicare over the next 10 years by $2 trillion over what it had projected for the same time period in 2009.[37] U.S.

Council on Compensation, Inc., 892 F. Supp. 1503 (S.D. Fla. 1995), aff'd, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rate-making organization to make temporary employee services pay higher workers' compensation rates was exempt business of insurance).

[36] Key Facts about the Uninsured Population, Kaiser Family Foundation (Sep. 29, 2016), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[37] Harry Stein and Laura Pontari, The Medicare Cost Curve Bent During the Obama Administration, Center for American Progress (Aug. 9, 2016),

healthcare spending projections "are $2.6 trillion lower than the original post-ACA baseline forecast through 2020 — a reduction in projected spending of almost 13%."[38] Income and wealth inequality, a topic that has appeared in numerous policy debates since the Great Recession, is exacerbated by differences in access to a much lesser degree as a direct result of the ACA.

Review of the ACA is essential. In many counties, too few insurers compete. Many counties have only a single insurer. Navigating choices between highly complex products remains difficult for consumers, leading to less robust benefits of competition. Perhaps most importantly, premiums are increasing rapidly and are still unaffordable for many Americans and high deductibles leave people underinsured and vulnerable to sudden, large expenses.

Reforms should build on existing successes to improve competition, consumer choice, transparency, and value. Amending the McCarran-Ferguson Act to eliminate the health insurance antitrust exemption is an important step toward this goal, but its scope is limited. In order to improve healthcare markets and make coverage more affordable, Congress must recognize the critical, common-sense provisions of the Affordable Care Act and how they improve competition and preserve or strengthen many of those provisions.

Several ACA provisions do not regulate prices but rather encourage "(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." It is important to keep these provisions because they create a level playing field on which plans can compete and a "floor" that consumers can depend on as a minimum level of protection. Free market advocates and consumer advocates alike know that a level playing field is necessary for markets to function in the best interests of consumers. Industries should be able to adapt to a reasonable regulatory framework, as long as competitors are held to equal standards.

The provisions in the ACA that help protect consumers and level the playing field are reduced variation, rate review, a ban on discriminatory plan designs, and MLR (medical loss ratio).

a. ACA Provisions are Necessary to Make Health Insurance Markets Work and Protect Consumers

For consumers to exercise their power in the health insurance marketplace, regulators need to level the playing field vis-a-vis health plans. It is challenging for consumers to assess and understand health insurance products and and excessive product variation and too many choices can make consumers worse off, not better. The ACA introduced several provisions to address these concerns.

A manageable number of "good" choices better than many choices. Consumers Union

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https://www.americanprogress.org/issues/healthcare/news/2016/08/09/142386/the-medicare-cost-curve-bent-during-the-obama-administration/.

[38] Michael Hiltzik, Obamacare update: Still succeeding, repeal fading, Los Angeles Times (June 21, 2016 9:36 AM), http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-succeeding-20160621-snap-story.html.

published a report showing that more choice is not better when it comes to shopping for health insurance. The best thing for the market is to allow shoppers to choose from a manageable number of products that meet a minimum quality standard.

Standardizing the scope of covered benefits to a comprehensive level helps reduce the number of plan attributes that can vary and gives consumers the peace of mind that they will not find surprise coverage gaps in their plan. Removal of annual and lifetime limits also reduces the plan attributes that can vary and helps spread the expenses of the sickest consumers across a broad pool.

Actuarial value tiers, known as "bronze, silver, gold, and platinum" plans,[39] correspond to the percentage of expenses the health plan will pay, and are easily understood by consumers as representing understandable levels of plan generosity. Consumer testing in Massachusetts and California suggest that standardizing cost-sharing into a limited number of consumer friendly designs would provide even more help to shoppers.

i. Rating Rules and Review help prevent anticompetitive conduct

Consumers want premiums to be fair. The rating rules and efforts to strengthen state review processes established by the ACA is a major source of consumer protection. It bans medical underwriting, a practice that made it difficult for consumers to get coverage and huge costs into the premium before the ACA was passed. Today, instead of buying individually underwritten plans, individuals consumers enter a risk pool which "guarantees issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange."[40] The ACA grants more resources to the states to enforce a federal "floor" of protections through rate review and banning discriminatory plan designs. As of April 2016, forty-six states have effective rate review programs in both the individual and small group markets. In the four states which do not (AL, MO, TX, WY), federal rate review will be conducted until the state can provide effective rate review.[41] According to CMS, "Improved rate review has reduced total premiums in the individual and small group markets by approximately $1 billion in 2013 and $1.2 billion in 2012."[42]

ii. Medical Loss Ratio deters the exercise of market power

In a highly concentrated market firms can exercise market power. To address this issue the ACA established Medical Loss Ratio standards (MLR) to ensure that a certain amount of health care premiums result in direct benefits to consumers (and not administrative costs or

[39] What the Actuarial Values in the Affordable Care Act Mean, Kaiser Family Foundation (Apr. 2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf.
[40] Summary of the Affordable Care Act, Kaiser Family Foundation, http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.
[41] State Effective Rate Review Programs, CMS, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet.html.
[42] *Id.*

profits). MLR regulations "require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets."[43] Health insurance companies were required to pay $469 million in rebates to about 5.5 million people in 2014;[44] the total over four years was more than $2.4 billion. This is a consumer protection that does not work on its own, however. In the absence of competition or regulation, insurers will simply expand the "pie" (enrollee premiums) and take their bigger - yet still compliant - slice.[45]

iii. The ACA strengthens State Protections

Critics of the ACA argue that states are adequate, if not better, at regulating insurance and protecting consumers than the Federal government. While it is true that states are closer to the front lines, they are also almost certainly under-resourced. Evidence shows a general inability to resolve issues faced in this industry on the state level.

Hence, the ACA protected consumers with a federally mandated "floor" of protections, as described above, but States can guarantee more protections to consumers if they so choose. The ACA also provided for flexibility via waivers, as long as consumers were not worse off nor the federal deficit increased. Finally, the ACA provided grants to help increase state capacity to meet the needs of their residents. For example, in all states, consumers can guarantee they will not be subjected to discriminatory plan design, such as structuring a plan so all HIV/AIDS patients pay out-of-pocket for all HIV/AIDS-related treatment.

iv. Exchanges provide an invaluable marketplace fostering competition

Exchanges provide an infrastructure and a forum for supply and demand to meet, where buyers are in a better position to demand value due to regulation and transparency. Indeed, the Exchanges are one of the most overtly "pro-competition" aspects of the Affordable Care Act, described by Congressman Johnson of Georgia as "explicitly designed to facilitate competition among insurers."[46]
Early studies show the structure of the exchanges encouraged new entry; HHS reported that 88% of enrollees lived in counties with at least three insurers in 2016, up from 70% in 2014.[47] Recent

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[43] Summary of the Affordable Care Act, *supra* note 40.

[44] Consumers Get Rebates, More Premium Value and Stability Protection in 2014, CMS, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014_Medical_Loss_Ratio_Report.pdf.

[45] Testimony of Leemore Dafny, Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?, Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights, http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[46] *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the H. Judiciary Comm.*, 114th Cong. 114-47 (2015).

[47] Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace, ASPE (Oct. 30, 2016), https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

exits by insurers from the exchanges are disappointing. However, a judge found that Aetna's exit in some territories appeared to be a strategic move to avoid antitrust scrutiny, rather than an outright rejection of the exchange model.[48] Further legislation and reform could help exchanges become more robustly competitive in the future, potentially using California as a model.

Active Purchaser exchanges, such as in California, have been particularly successful because they employ an overarching entity to oversee the "playing field," keeping it as level and fair to consumers as possible. A Brookings Institution study found that California had the "healthiest" Obamacare exchange, with its "uninsured rate [down] from 17.2 percent to 8.1 over four years… The report attributed that to several factors: Covered California's ability to 'somewhat aggressively' negotiate premiums with insurers; its insistence on consistent benefit offerings among all insurers; a large and stable number of insurers – 11 – offering plans; and a large network of 'navigators' (community groups and individuals who helped enrollees sign up)."[49] Rather than offering consumers plans as long as they comply with the ACA, California's exchanges represent a higher standard due to these proactive efforts by the state.

b. Vigorous Antitrust Enforcement is Essential to Making the Market Work

Repeal of MFA will do nothing without a tough antitrust cop on the beat. In 2009, when I was last here to discuss MFA, competition was in a sorry state. Regardless of any statutory antitrust exemption the DOJ had provided a de facto antitrust exemption. It brought no cases against anticompetitive conduct by health insurers. There were over 400 health insurance mergers and the DOJ did not challenge a single one. The abysmal enforcement record under the earlier Administration had greatly cost consumers. Permitted mergers, like the 2008 Nevada merger of Sierra Health and UnitedHealth, had a tremendous impact on prices. A study of small-group premiums in two Nevada markets found that premiums increased by 13.7 percent the year following the merger.[50] The result of this enforcement celibacy -- ten of the largest health insurers saw their profits balloon 428 percent, from $2.4 billion in 2000 to $13 billion in 2007.[51]

Today, we are in a far better position. The Obama antitrust authorities significantly revived health insurance antitrust enforcement. We now have the opportunity to build on the strong recent enforcement record of the DOJ, especially with the passage of H.R. 372.

Here are examples of some of the recent actions that have revived health insurance antitrust enforcement.

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[48] U.S. v. Aetna Inc., No. 16-1494 (D.D.C. filed Jan. 23, 2017).

[49] Claudia Buck, California gets high marks on running state's Obamacare exchange, The Sacremento Bee (Feb. 9, 2017), http://www.sacbee.com/news/local/article131852734.html.

[50] J. R. Guardado, D. W. Emmons, and C. K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra," Health Management, Policy and Innovation, June 2013 1(3):16–35.

[51] Mark Gendernalik, "Domestic Policy Subcommittee Oversight and Government Reform Committee," Statement before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform, September 16, 2009, available at
http://groc.edgeboss.net/download/groc/domesticpolicy/prepared.testimony.of.mr.mark.gendernalik.pdf.

i. The DOJ and State of Michigan's Suit Against BCBS of MI Use of Most Favored Nations Clauses Sent a Clear Signal to the Market

In 2010, the DOJ, along with the state of Michigan, filed suit against BCBS of MI for its alleged anticompetitive use of most favored nations clauses ("MFNs") in its contracts with hospitals to disadvantage rivals. These MFNs required a hospital either to charge BCBS of MI no more than it charges BCBS of MI's competitors, or to charge the competitors a specified percentage more than it charges BCBSM, in some cases between 30 and 40 percent. The MFNs caused some hospitals to demand prices too high to allow competitors to compete, effectively barring them from the market. The DOJ's complaint also alleged that BCBS of MI agreed to raise the prices that it pays certain hospitals to obtain the MFNs, thus buying protection from competition by increasing its own costs.

The facts of this case caused the state legislature to sit up and take notice. Thanks to this case, the state of Michigan enacted legislation on March 18, 2013 that, among other reforms, prohibits health insurers, including BCBSM, from including or using MFNs in provider contracts. This was a substantial victory for consumers and competition that would not have been possible without strong enforcement from the DOJ.

ii. The DOJ's Recent Victories Blocking the Proposed Anthem/Cigna and Aetna/Humana Mergers Greatly Benefited Consumers

In July 2015, four of the largest health insurance companies in the market announced two mega-mergers -- Aetna's merger with Humana, and Anthem's acquisition of Cigna.[52] Aetna proposed the purchase of Humana for $37 billion. The merger would have resulted in a combined entity servicing 33 million beneficiaries. Anthem attempted to acquire Cigna for $54 billion, and a combined firm would serve 53 million members. Even more substantial, collectively Anthem and other Blue Cross or Blue Shield plans control 105 million lives. The addition of Cigna would have added 14.7 million more, representing a 14 percent increase in the lives controlled by Blue plans across the U.S.[53] The total would have been equivalent to roughly one-third of the U.S. population.

Five insurers dominate the U.S. market for health insurance (Aetna, Humana, Anthem, Cigna and UnitedHealth). The mega-mergers would have resulted in three national health insurers remaining in the market. Following approximately year-long investigations, in July 2016 the DOJ filed two suit to enjoin the two mergers. Then U.S. Attorney General Loretta Lynch

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[52] This committee held a hearing to discuss health insurance mega-mergers in September, 2015. Members and a diverse panel of experts contributed testimony and data about health insurance markets that has proven highly valuable as Congress considers health insurance market reforms. *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the H. Judiciary Comm.*, 114th Cong. 114-47 (2015).

[53] Letter by the American Hospital Association to the Department of Justice commenting on the Anthem-Cigna merger (Feb. 29, 2016).

stated “These mergers would restrict competition for health insurance products sold in markets across the country and would give tremendous power over the nation’s health insurance industry to just three large companies. Our actions seek to preserve competition that keep premiums down and drives insurers to collaborate with doctors and hospitals to provide better healthcare for all Americans.”[54]

Aetna-Humana

On July 21, 2016 the DOJ, eight states and the District of Columbia sued to enjoin the Aetna-Humana merger.[55] The complaint alleged that the merger would greatly reduce Medicare Advantage competition in over 250 counties across 21 states, impacting over 1.5 million Medicare Advantage members. Additionally, the complaint alleged the deal would harm competition to sell commercial health insurance to individual and families on the public exchanges in Florida, Georgia and Missouri, hurting over 700,000 individuals.

Judge John Bates held a 14-day bench trial before deciding to enjoin the merger, during which he heard from approximately 30 witnesses from both sides. Much of the DOJ’s focus was on the competition between the insurers for Medicare beneficiaries. The insurers attempted to argue that Medicare Advantage and Traditional Medicare are in the same market, meaning the market for Medicare services is vastly broader than a market specific to Medicare Advantage. However, Judge Bates did not by the insurers’ market definition and ruled that the merger would substantially reduce competition for Medicare Advantage plans in 364 counties. He held that the evidence presented by the DOJ suggested significant head-to-head competition, which drives improvements to plan cost and quality, and that if the merger were consummated, that competition would be lost, resulting in deterioration in the Medicare Advantage products offered.

The trial was also tainted by Aetna’s withdrawal from ACA individual market exchanges. Aetna withdrew from all 17 exchanges alleged to be problematic shortly after the DOJ’s complaint was filed, including exchange where their presence was profitable. While suspected by DOJ that Aetna’s withdraw was an attempt to thwart antitrust scrutiny, Judge Bates round that the withdraw was done solely to improve its litigation position. However, Judge Bates only identified three counties in Florida where Aetna was likely to compete after 2007. Nonetheless he ruled that the merger would substantially lessen competition in those three counties.
As of February 14, Aetna and Humana have abandoned the attempted merger.

Anthem-Cigna

On July 21, 2016 the DOJ, eleven states and the District of Columbia sued to block Anthem’s takeover of Cigna. The suit against Anthem and Cigna alleged that the merger would reduce competition for millions of consumers who receive coverage through their large-group employers in at least 45 metropolitan areas, and from public exchanges in St. Louis and

[54] Press Release, Justice Department and State Attorneys General Sue to Block Anthem’s Acquisition of Cigna, Aetna’s Acquisition of Humana, DOJ (July 21, 2016), https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s.
[55] Complaint, U.S. v. Aetna, No. 16-1494 (D.D.C. filed July 21, 2016).

Delaware. It was also alleged that the acquisition of Cigna threatened competition among commercial insurers for the purchase of healthcare services from providers.

The merger trial was overseen by Judge Amy Berman Jackson, which lasted 20 days and saw 27 witnesses. Judge Jackson ultimately ruled in favor of the DOJ blocking the merger finding that the merger is likely to harm competition.[56] The DOJ argued against the merger from two-sides of the market – one that the merger will increase costs for consumers, and two that it will decrease reimbursement costs for providers in the markets at issue. Judge Jackson agreed and recognized that Anthem was asking the court for significant leeway and "go beyond what any court has done before: to bless this merger because customer may end up paying less to healthcare providers for the services that the providers deliver even though the same customers are also likely to end up paying more for what the defendants sell…" In her findings Judge Jackson wholly refuted the insurers' argument that efficiencies would be pro-consumer and a counter-weight to potential competitive problems.

Also telling in Judge Jackson's decision to block the merger was the highly abnormal relationship between two merging parties – Cigna seemingly actively worked against the merger. Judge Jackson noted that the DOJ was not the only party raising questions about Anthem's characterization of the outcome of the merger. "Cigna officials provided compelling testimony undermining the projections of future savings, and the disagreement runs so deep that Cigna cross-examined the defendants' own expert and refused to sign Anthem's Findings of Facts and Conclusions of Law on the grounds that they 'reflect Anthem's perspective' and that some of the findings 'are inconsistent with the testimony of Cigna witnesses.'"

Economic theory underlying horizontal merger enforcement shows that without sufficient competition, companies do not have incentives for passing savings through to consumers. In rejecting both mergers, the courts affirmed that the health insurance market's high concentration level warrants close scrutiny of any action that would increase firms' market power. The mergers were wins for millions of consumers who will not suffer increased premiums and decreased healthcare services due to undue concentration.

Conclusion

Health insurance is at a crossroads and trying to enhance competition in these competitively fragile markets is an important national priority. Antitrust exemptions typically impose costs on competition and consumers and as the Antitrust Modernization Commission has observed are disfavored and face a very difficult task to be justified. The MFA cannot meet the standards suggested by the AMC that is why this Committee should endorse H.R. 372, Competitive Health Insurance Reform Act of 2017.

This Committee should go further to protect health insurance competition. Strong, vigorous antitrust enforcement is essential to making the market function. This Committee should use its oversight function to ensure that the progress in health insurance antitrust

[56] U.S. v. Anthem, Inc., No. 16-1493 (D.D.C. filed Feb. 8, 2017).

enforcement is not weakened. Competition, regulation, and robust antitrust enforcement must all come together to make health insurance markets function properly and deliver high quality products at a reasonable price to consumers. As Congress plans its next steps and the fate of the Affordable Care Act, it must take into consideration how vital these protections and regulations have been for the health of the market as well as protecting tens of millions of people from harm. Without these key provisions, health insurance markets will become highly unstable and consumers, patients, and families will pay the price.

Appendix

Healthcare Advocacy of David Balto

- Formed the Coalition to Protect Patient Choice, a consumer-supported organization to oppose the Aetna-Humana and Anthem-Cigna mergers. (See www.TheCPPC.com). Submitted comments in opposition to the mergers in 12 states: California, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Missouri, New York, Ohio, Virginia and Wisconsin. Testified in opposition to the mergers in 6 states: California, Delaware, Missouri, New York, Virginia and Wisconsin. Testified before the national Association of Insurance Commissioners. Presentations to the DOJ and over state attorneys generals offices.

- Provided expert testimony on health care competition before Congress 14 times.
  - Testimony on Pharmacy Benefit Management Competition, Before the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law, November 17, 2015.
  - Testimony on the ACA, Consolidation and the Impact on Competition in Health Care, Before the House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law. September 19, 2013.
  - Testimony on the Express Scripts-Medco PBM Merger, Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy, and Consumer Rights. December 6, 2011.
  - Testimony on Health Industry Consolidation, Before the House Committee on Ways and Means, Subcommittee on Health. September 9, 2011.
  - "The Need for a New Antitrust Paradigm in Health Care," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy on Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients. December 1, 2010.
  - "Antitrust Enforcement Agencies Face Unprecedented Challenges," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy. July 27, 2010.
  - "Oversight of the Enforcement of the Antitrust Laws," Testimony Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Protection. June 9, 2010.
  - "Protecting Consumers and Promoting Health Insurance Competition," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy. October 8, 2009.
  - "The Effects of Regulatory Neglect on Health Care Consumers," Testimony Before the Senate Committee on Commerce, Science and Education. July 16, 2009
  - "A Progressive Agenda for Antitrust Enforcement at the Antitrust Division," Testimony Before the Senate Judiciary Committee. March 10, 2009.
  - "A Progressive Vision for Antitrust Enforcement to Protect the Opportunities for Small Businesses and to Protect Consumers," Testimony Before the House Small Business Committee. September 25, 2008.
  - Testimony on the Proposed Recommendations for Consideration on the Proposed Merger of Highmark and Independence Blue Cross, Before the Senate Banking and Insurance Committee. September 23, 2008.

- "Consumers Suffer as Health Insurers Consolidate," Testimony Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy, and Consumer Rights. July 31, 2008.
- "The Impact of our Antitrust Laws on Community Pharmacies and Their Patients," Testimony Before the House Judiciary Committee, Antitrust Task Force. October 18, 2007.

- Led consumer advocacy in favor of pay-for-delay legislation designed to ensure increased generic drug entry into the U.S. market.

- Led consumer advocacy in opposition to the Teva Pharmaceutical takeover of Mylan.

- Led consumer advocacy in opposition to the CVS Health-Omnicare merger.

- Led consumer advocacy against Partners Healthcare acquisition of South Shore Hospital in the Boston, Massachusetts area.

- Provided expert testimony to the Department of Labor, ERISA Advisory Council concerning the necessity of pharmacy benefit management compensation and fee disclosure to welfare benefit plans.

- Led consumer, payor and provider opposition to the pharmacy benefit manager merger of Express Scripts and Medco.

- Provided expert testimony on the UPMC-Highmark dispute in the Pittsburgh, Pennsylvania area before the Pennsylvania State Senate Committee on Banking and Insurance.

- Provided expert testimony in opposition to the Highmark/Independence Blue Cross merger in Pennsylvania, which was ultimately disbanded by the Pennsylvania State Senate Committee on Banking and Insurance.

- Led consumer and provider opposition to the UnitedHealth-Sierra merger affecting the state of Nevada.

- Served as an expert witness for the state of Maine in *Pharmaceutical Care Management Ass'n v. Maine Atty. Gen.*, 1:03-cv-00153 (D. Me. 2003) brought by the association representing pharmacy benefit managers challenging a statute designed to regulate pharmacy benefit managers in the state.