DEPARTMENT OF JUSTICE

Antitrust and Healthcare

CHRISTINE A. VARNEY
Assistant Attorney General
Antitrust Division
U.S. Department of Justice

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Thank you for inviting me to speak to you today about the importance of antitrust enforcement and competition policy in health care. As you all know, our health care system is undergoing significant reform designed to bring more affordable insurance and more affordable care to American consumers. The Department of Justice generally, and the Antitrust Division specifically, has a substantial role to play to ensure that reform is achieved, competition is maintained, and consumers are benefited. The Patient Protection and Affordable Care Act (the Affordable Care Act), called for by the President and enacted by Congress on March 21, relies, in part, on the belief that robust competition and expanded choice will expand coverage while containing cost.[1] To be sure, implementing this vision will involve an unprecedented effort for federal and state regulators. Yet, like many reforms driven by the power of competition to create consumer welfare, the success of these legislative and regulatory efforts will depend as much upon healthy competitive markets free from undue concentration and anticompetitive behavior as it will upon regulatory change. In short, enactment of the Affordable Care Act makes effective antitrust policy more important than ever.

In that regard, I am hopeful that health care reform is not completely over on the legislative front. As you know, in February the House voted overwhelmingly, 406 to 19, to repeal the McCarran-Ferguson Act with regard to health insurance.[2] The Administration has issued a Statement of Policy strongly supporting repeal.[3] As the Administration's Statement notes, health care reform should be built on a strong commitment to competition in all health

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[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2010).

[2] Health Insurance Industry Fair Competition Act, H.R. 4626, 111th Cong. (2010).

[3] Statement of Administration Policy on H.R. 4626 (Feb. 23, 2010), *available at* http://www.whitehouse.gov/omb/assets/sap_111/saphr4626r_20100223.pdf.

care markets, including health insurance. The repeal of the antitrust exemption in the McCarran-Ferguson Act as it applies to the health insurance industry would give American families and businesses, big and small, more control over their own health care choices by promoting greater insurance competition and outlawing anticompetitive health insurance practices like price fixing, bid rigging, and market allocation that drive up costs for all Americans. These steps go hand in hand with the reforms that have already been enacted.

As I am sure you have heard, the United States spends an exceptionally high amount on health care. In 2009, U.S. health care expenditures were projected to be over 17 percent of GDP—or about $2.5 trillion—accounting for 1/6th of the U.S. economy.[4] Such a large "part of the trade or commerce among the several states," to use the words of the Sherman Act, would make health care a vitally important sector for antitrust enforcers even if there had been no health care reform. The Affordable Care Act, and the prospect of expanded consumer choice, only increases this importance.

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

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[4] Christopher J. Truffer et al., *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFFAIRS 1 (March 2010), *available at* http://www.politico.com/static/PPM136_100203_ health_projections html.

Both of these initiatives are even more important with the advent of health care reform. Two significant aspects of the Affordable Care Act are the establishment of new competitive marketplaces—known as Exchanges—for individuals and small employers to purchase health insurance, and the formation of Accountable Care Organizations (ACOs) and other initiatives to provide for more efficient delivery and payment of Medicare services and Medicaid pediatric services. There can be no doubt that the success of the Exchanges and the ACOs will depend, in large part, on effective competition, both among health care insurers and providers. Moreover, clear and accessible guidance on antitrust issues associated with both can also contribute to their success.

The ultimate goal of health care reform is to harness the power of competition, together with regulation, to expand coverage, improve quality, and control the cost of health care for all Americans. The role of antitrust is to ensure that competition is preserved and protected, so that it is there to be harnessed. I hope that by the end of my remarks, you will agree that the Antitrust Division is doing all it can to fulfill this indispensible role.

I. Enforcement

Vigorous but responsible antitrust enforcement has long been, and will continue to be, crucial to the health care industry. This includes health insurance plans, providers, and others in the industry. The goals of health care reform cannot be achieved if mergers between significant insurers in a particular market substantially reduce competition; nor can those goals be realized if dominant insurers use exclusionary practices to blockade entry or expansion by alternative insurers. The same is true if health care providers use supposedly quality-improving or cost-reducing measures simply to raise prices. Thus, the Antitrust Division has undertaken, and will

continue to undertake, measured enforcement to prevent such anticompetitive behavior. Let me give you a recent example.

In March, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan (PHP) abandoned their plans to merge because the Division informed the companies that it would challenge the proposed transaction. The companies were the two largest providers of commercial health insurance in the Lansing area. Blue Cross-Michigan had almost a 70 percent market share in Lansing. PHP was its largest competitor with a market share of approximately 20 percent.[5]

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

One critical question in the investigation was whether competition from future entrants was likely to constrain Blue Cross-Michigan's exercise of market power. To enter successfully,

[5] Press Release, U.S. Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (March 8, 2010), *available at* http://www.justice.gov/atr/public/press_releases/2010/256259.pdf.

new insurers would have needed to develop networks of hospitals, physicians, and other health care providers at rates comparable to the dominant incumbent's. Our investigation found that entrants were unlikely to be able to establish a competitive provider network at comparable rates in Lansing, which would have prevented or significantly delayed the level of entry necessary to defeat an anticompetitive price increase.

To us, this was not surprising. Over the last ten years in numerous investigations across the country, the Division has found that many providers give the best discounts only to insurers with significant market share. Thus, new entrants cannot negotiate for competitive provider discounts because they have few enrollees, and they cannot win new enrollees because they do not have competitive discounts. This situation makes it difficult for insurers to enter new geographic areas or for insurers with small enrollment to expand within existing markets.

At the same time, the Division is sensitive to the capacity of certain mergers or collaborations to improve efficiency both in health care and health insurance markets, and so we have pursued a measured approach. Over the past year, we have closed investigations in the health insurance market after thoroughly analyzing our initial concerns and satisfying ourselves that the transactions were unlikely to pose a competitive problem.[6] Where the Division has been convinced through direct evidence and economic analysis that a practice or proposed combination is not likely to result in a substantial lessening of competition, we have not challenged it.

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[6] An example of such is UnitedHealth Group's proposed acquisition, in the second half of 2009, of the right to renew Health Net's contracts with customers in Connecticut, New York, and New Jersey. Our investigation focused on three areas in which the parties' businesses overlapped: commercial health insurance, Medicare Advantage insurance, and the purchase of physician and hospital services. The Division did not seek to block the transaction because we concluded that competition from other market participants was likely to prevent the merged firm from acting anticompetitively in any of these markets. With respect to Medicare Advantage insurance, for example, the merging firms did not significantly compete with each other. While Health Net had a 65 percent share of the non-special-needs Medicare Advantage market in Connecticut, United had only a 4 percent share, and at least three other insurers competed with them. Conversely, while United accounted for 64 percent of special-needs Medicare Advantage enrollment in Connecticut, Health Net only accounted for 1 percent.

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

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

II. Competition Advocacy

It is important to keep in mind that successful antitrust enforcement also includes effective competition advocacy. For example, in 2008, the Division filed an important set of comments involving the Michigan state legislature's consideration of a certificate of need (or CON) requirement as a precondition to opening a new facility. The comments focused on a

proposed CON standard for Proton Beam Therapy Services, an important treatment for cancerous tumors.[7] As the Division's letter made clear, the CON standards "[had] the potential to delay or exclude a competing and perhaps superior technology from entering the marketplace" without yielding any real offsetting advantages because the market itself could determine the "need" for the facility.[8] Relying on this same analysis, Governor Granholm vetoed the legislation and made clear that a policy of open competition would best serve Michigan consumers. This was a particularly important step because, as our letter noted, the state action doctrine often protects such programs from antitrust enforcement.[9] Consequently, competition advocacy was likely the only avenue for promoting and protecting competition in this context.

Our business review program provides another avenue for effective competition advocacy in the health care industry. For example, the Division recently issued a business review indicating that we would not challenge a proposal to establish an information exchange program providing data on the relative costs and resource efficiencies of more than 300 hospitals in California.[10] A coalition of three group purchasers of health care services, serving more than seven million people, proposed to collect, analyze, and distribute aggregated comparative data on the level of reimbursement received, and the resources used, by California hospitals in providing inpatient and outpatient services. In response to the coalition's business review request, we stated that the proposed exchange could reduce health care costs by improving competition among hundreds of hospitals in California and facilitating more informed purchasing decisions

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[7] Letter from Joseph Miller, Assistant Chief, Litigation I Section, Antitrust Div., U.S. Dep't of Justice, to State Senator Michael D. Bishop (Jun. 6, 2008), *available at* http://www.justice.gov/atr/public/comments/234407.pdf.

[8] *Id.* at 2.

[9] *Id.* at 3.

[10] Letter from Christine A. Varney, Assistant Attorney Gen., U.S. Dep't of Justice, to Mit Spears, Esq. (April 26, 2010).

by group purchasers of health care services. We noted that the program was likely to provide greater information and increased transparency about the relative costs and utilization rates of hospitals in California to payers and employers. It was also unlikely to produce anticompetitive information-sharing effects because the program would disclose only aggregate data and would involve only data that was at least ten months old.

III. Entry Project

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

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

We reached several important conclusions. First, and foremost, we confirmed that the biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Second, we concluded that it may be easier to enter less concentrated markets, with competition between several large but relatively equal-sized insurers, than it is to enter a market with one or two dominant plans. This is a vitally important finding because it illustrates that a critical economic assumption in antitrust analysis—namely, that the higher profits often associated with concentrated markets will attract new entrants who will help restore competitive pricing—is sometimes made without an adequate evidentiary basis. Indeed, this assumption fails to account for barriers to entry, including barriers based on the inability of entrants to achieve economies of scale that will allow them to compete with incumbents.

One partial explanation for the presence of this phenomenon in health insurance markets comes from our third finding, which is that new entrants or niche players are more likely to receive provider discounts comparable to their competitors' in less concentrated markets than they are in markets dominated by one or two plans. This is because no one plan provides such a large number of enrollees that it can demand, and likely receive, disproportionately larger provider discounts than other incumbents or possible entrants. Not only does this mean that, as antitrust enforcers, we need to take these issues into account as we assess likely entry in given health insurance mergers, but it also means that we will need assurances that provider discounts that larger insurers can obtain post-merger will be passed on to consumers. Finally, our interviews reconfirmed that brokers typically are reluctant to sell new health insurance plans,

even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates.

These conclusions reinforce our concern about strong barriers to entry and expansion in health insurance markets and are particularly significant in light of the enactment of the Affordable Care Act. As I noted earlier, one of the major goals of health care reform is to provide individuals and small businesses with more affordable health insurance options through competition in new state-based health insurance marketplaces called Exchanges. For the Exchanges to succeed, however, they must be able to "harness the power of competitive market incentives as fully as possible."[11] It is, therefore, imperative that the Division prevent mergers or acquisitions that will create, or even increase the size of, dominant health insurance plans, particularly in the small-group and individual markets. As we learned from our entry inquiry, it may be much more difficult for a firm to enter or expand in a market with one or two dominant firms than it is in one with more equal-sized firms. Incumbent, dominant firms may also engage in exclusionary practices to deter entry by new firms and further hinder the development of competitive Exchanges.

Thus, our entry initiative suggests three important takeaways for the health insurance industry. First, the Justice Department will carefully review mergers in the health insurance industry and will continue to challenge those mergers that are likely to substantially lessen competition in properly defined antitrust markets. The infrequent entry of new choices makes it even more important to preserve the choices already available. Second, entry defenses in the health insurance industry generally will be viewed with skepticism and will almost never justify an otherwise anticompetitive merger. Third, you should expect the Justice Department to

[11] Statement of Representative John Conyers, Jr.,156 CONG. REC. E455-56 (2010) (emphasizing the important advisory role of the antitrust enforcement agencies in helping federal and state agencies formulate policies and regulatory decisions consistent with competitive market incentives).

carefully scrutinize and continue to challenge exclusionary practices by dominant firms—whether for-profit or non-profit—that substantially increase the cost of entry or expansion. This is particularly so with respect to most-favored-nations clauses and exclusive contracts between insurers and significant providers that reduce the ability or incentive of providers to negotiate discounts with aggressive insurance entrants. Attention to these three takeaways is the cornerstone of appropriate antitrust enforcement in this important sector of our economy, and, with these insights, we look forward to helping state and federal regulators as they develop their rules and recommendations for health insurance Exchanges.

IV. Innovation and Efficiency in Health Care Delivery

Let me close with a few remarks about the role of antitrust in promoting innovation and efficiency in health care delivery. There can be no doubt that vigorous yet responsible antitrust enforcement is crucial if we are to benefit from innovation and efficiency in our health care delivery system and reduce rising health care costs in both the public and private sectors.

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

There does not seem to be serious dispute that clinical integration and coordinated care have the potential to decrease costs and improve quality. The key is whether we can gain those benefits without sacrificing meaningful competition.

The answer to that question is undoubtedly "yes." The Health Care Policy Statements and business reviews of the federal antitrust enforcement agencies make clear that antitrust is not

an impediment to the formation of innovative, integrated health care delivery systems and genuine increases in provider efficiency.[12] There are many ways under the federal antitrust laws for providers to form joint ventures to control costs and improve quality without unduly inhibiting competition. They can financially integrate, or they can clinically integrate, or, indeed, they can do both. As I said in 1996, when I was a Commissioner at the Federal Trade Commission, the federal antitrust enforcement agencies should be receptive to new and innovative forms of provider arrangements that do not necessarily involve financial risk sharing.[13] As the Policy Statements emphasize, antitrust's ultimate objective is that there be sufficient network integration—whatever that integration may be—for the network to achieve significant, material efficiencies that will benefit consumers.

The Policy Statements discuss what can constitute sufficient clinical integration.[14] They note the role, and import, of establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; selectively choosing network providers who are likely to further these efficiency objectives; and making significant investments in network infrastructure and capability so as to realize these claimed efficiencies.

Our colleagues at the Federal Trade Commission have applied this analysis in a number of advisory opinions involving questions of clinical integration. The advisory opinions confirm that the touchstone of clinical integration analysis is the adoption of a comprehensive, coordinated program of care management designed, and likely, to improve quality and cost-

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[12] DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, STATEMENT 8 (1996) [hereinafter HEALTH CARE POLICY STATEMENTS], *available at* http://www.justice.gov/atr/public/guidelines/1791.pdf.

[13] Separate Statement of Commissioner Christine A. Varney on the Revised Health Care Guidelines (Aug. 1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/varney htm.

[14] HEALTH CARE POLICY STATEMENTS, *supra* note 7, at 8.B.1.

effective care. Only that kind of program—with its emphasis on realizing benefits for consumers—justifies rule-of-reason treatment for price setting or other agreements that might otherwise be per se illegal.

For example, the FTC's 2009 *TriState Health Partners* advisory opinion involved a proposal by a physician-hospital organization to clinically integrate its members' provision of health care services and to contract jointly with health plans and other payers on a fee-for-service basis.[15] Similarly, the FTC's 2007 *Greater Rochester Independent Practice Association* advisory opinion involved a physician association's proposal to negotiate contracts with payers in connection with its integrated services program.[16] In both of these matters, providers, through the use of IT systems, practice guidelines, care protocols, referral policies, and quality benchmarks, sought closely to align their efforts to improve their patients' health and delivery of services. In both ventures, the participating providers substantially integrated their activities in order to establish a comprehensive, aggressive program of care management that would increase efficiency and improve quality of care.

The Policy Statements also provide numerous examples of sufficient financial integration.[17] There can be, among other things, an agreement to provide services at a capitated rate, or to provide particular services for a predetermined percentage of the premium or a predetermined revenue stream. There also could be, for instance, the use of significant financial incentives to achieve specific cost-containment goals, or the agreement to treat complex cases for a fixed, predetermined fee. The point is that, however it is to be achieved, it is incumbent upon

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[15] Fed. Trade Comm'n, Bureau of Competition, Staff Advisory Op., TriState Health Partners, Inc., (April 13, 2009), *available at* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf.

[16] Fed. Trade Comm'n, Bureau of Competition, Staff Advisory Op., Greater Rochester Independent Practice Association, Inc. (Sept. 27, 2007), *available at* http://www ftc.gov/bc/adops/gripa.pdf.

[17] HEALTH CARE POLICY STATEMENTS, *supra* note 7, at Statement 8.A.4.

the group to share financial risk in such a way that each member has an economic incentive to ensure that the group as a whole produces material efficiencies that will benefit consumers.

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

The economic integration that justifies application of the rule of reason to joint price negotiations with payers requires the sharing of some form of financial risk, such as an agreement by providers to accept a capitated rate, a predetermined percentage of revenue from a health plan, or sufficient clinical integration to induce the group's members to improve the quality and efficiency of the care they provide. While there is no particular formula that can cover all types of legitimate clinical integration, the key is that there must be sufficient clinical integration to motivate the kinds of changes that can achieve real cost-containment or other performance benchmarks. For example, indicia of clinical integration may include: adequate infrastructure; an adequate number of meaningful protocols for diagnoses and treatment of diseases; enforceable performance standards; and proof of physician commitment to the program. However, where purported efforts to integrate are principally a vehicle for obtaining and exploiting market power or simply a subterfuge for price fixing, then antitrust is there, as it should be, to protect competition and consumers.

The Affordable Care Act's development of ACOs is a good example of how providers might work together to deliver more efficient, high-quality care without inhibiting competition, so long as their collaborations are properly constructed. For example, the ACO encourages competing physicians, and possibly other providers, to coordinate care for a defined Medicare population through redesigning care protocols, utilizing health IT, investing in infrastructure, and meeting quality targets. If the ACO meets quality-of-care and cost targets, it can share the savings with HHS.

Properly constructed, ACOs have the potential to improve health care delivery and drive down costs. Thus, as reform moves forward, the Justice Department will work closely with HHS and providers to offer whatever guidance may be needed to ensure that providers pursue beneficial integrated ACOs without running afoul of the antitrust laws.

Indeed, we have recently started a dialogue with our colleagues at the Federal Trade Commission regarding two important topics with respect to clinical integration. First, we want to see if there are additional, or better, ways to reach out to clinical-integration stakeholders and convey the important message that antitrust is not an impediment to legitimate clinical integration and should not be a concern to those contemplating such efforts. Second, we want to see if we can improve, streamline, and make more transparent our review of integrated provider networks. Our ultimate goal is to ensure that health care providers have the necessary guidance to form innovative, integrated health care delivery systems without unduly confining providers to any particular delivery model.

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In conclusion, let me say that I hope I have made clear that the Justice Department believes that antitrust has—and will continue to have—an essential role to play in health care. If

health care reform is to harness the power of competitive markets to produce more and more efficient systems, then we must be up to the challenge of ensuring that our health care markets are, in fact, as competitive as possible—protected from undue concentration or anticompetitive conduct with vigorous but responsible enforcement and effective competition advocacy. In this dynamic environment, a successful effort will require more than "business as usual." It will require that we provide clear and accessible guidance to health care consumers, providers, and payers so that there is the predictability needed for health care reform to succeed. I think you will find the Department of Justice generally, and the Antitrust Division specifically, up to the task of ensuring that reform is achieved, competition is maintained, and consumers are benefited.

Thank you.