DEPARTMENT OF JUSTICE

The Role of Antitrust Enforcement in Health Care Markets

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Remarks as Prepared for the Delivery at
The New Health Care Industry Conference:
Integration, Consolidation, Competition in the
Wake of the Affordable Care Act
at Yale University

Washington, DC

November 13, 2015

Thanks to Dean Post and Professor Gluck for inviting me to help start the conference this morning. The turnout today is a tribute to Yale Law School, the School of Management, and the new Solomon Center and its focus on the governance, business, and practice of health care. I regret not being able to join you in person for today's conversations.

I also regret not being able to share the dais with Massachusetts' outstanding Attorney General—Maura Healey. She and her talented antitrust team have been tireless in ensuring that citizens of Massachusetts benefit from competition in health care markets. We are proud to partner with her and other state attorneys general to promote competition in health care markets.

You know the statistics. Health care continues to be among the largest—and fastest-growing—sectors of our economy. The federal government spends as much on health care as it does on anything else; state and local governments are in a similar predicament. Businesses spend on average more than $12,000 a year per person to provide health insurance coverage for their employees. Medical debt remains a leading cause of personal bankruptcies.

Competition is central to the provision of affordable quality health care in the U.S. It promotes innovation and helps deliver the best health outcomes for the lowest prices. Consumers benefit when they have meaningful choices among insurers and hospitals, physicians and therapists, prescription drugs and medical devices.

The Affordable Care Act is premised on the idea that consumers benefit from robust competition in both provider and insurer markets. The ACA's Health Insurance Marketplaces—the exchanges—depend on insurers competing based on the strength of their networks and the prices they offer. In turn, the exchanges make it easier for consumers to compare plans and give competitors additional access to a significant number of customers. On average, consumers can choose from plans sold by five different insurers. Studies confirm what common-sense already

tells us: consumers who use exchanges with more competition enjoy lower premiums than those who have few choices. Maintaining—and even expanding—competition among health insurers will bring more of these benefits to consumers.

The ACA also recognizes the value of legitimate collaboration by promoting accountable care organizations and clinical integration that can improve the quality of care while lowering costs. The Antitrust Division and our colleagues at the Federal Trade Commission worked closely with the Department of Health and Human Services to support these efforts by providing guidance as to when and how traditional competitors can collaborate without lessening competition and thereby harming consumers. The FTC/DOJ ACO Policy Statement describes how ACOs can benefit patients without violating the antitrust laws, including describing safety zones for some ACOs and the standards for applying the antitrust "rule of reason" to others. The launch of more than 700 public and private ACOs to date demonstrates the opportunities for new forms of clinical integration.

While the ACA promotes collaboration and integration, it does not and was not meant to give anyone a free pass from the antitrust laws. Indeed, the very harms that result from the exercise of market power—higher prices, fewer competitors, reduced innovation—are contrary to the law's goals.

Antitrust enforcement in health care should aim to prevent or remedy the acquisition and abuse of market power, just as it does in other industries. We don't pick winners and losers. Our job is to block mergers that threaten to reduce competition; our job is to challenge competitors who want to conspire rather than compete; and our task is to ensure that companies do not raise barriers that deny competitors the opportunity to enter new markets or expand their existing market presence.

The Antitrust Division and the FTC, often working with state attorneys general, have a long history of challenging insurer, hospital, and physician mergers that threaten to reduce competition substantially. Over the last decade and a half, the Division has either blocked outright or required divestitures from seven health insurance mergers. We did this to protect individual purchasers, employers buying small and large group insurance, Medicaid managed-care enrollees, and seniors who rely on Medicare Advantage. We have sued to protect competition in the purchase of physician services too, and have required divestitures to prevent anticompetitive reductions in physician payments. The FTC has done tremendous work—stopping a string of potentially anticompetitive hospital mergers across the country, and recently winning two appellate cases blocking mergers affecting markets for physician and hospital services.

Merger enforcement continues to be a priority. We look to the future, as the Clayton Act envisions. We don't just take a snapshot of the markets as we find them today, or as we found them yesterday; we assess how they are likely to evolve, including trends toward increased concentration. We look at how companies that deliver services locally for some customers also may increasingly compete regionally or nationally in other respects. We consider whether a merger among hospitals may create greater bargaining leverage over insurers, or vice versa, even when the merging parties do not compete to serve the same patients. And, as always, we will carefully weigh the benefits the mergers may provide. We recognize that mergers and other forms of integration can lead to cost savings and improved quality of care, and will credit legitimate efficiencies that will benefit consumers of health care services.

Not all acquisitions meet that test. Look at the stories about the underlying motivation for some recent hospital acquisitions of physician practices. It is undisputed that Medicare and

many private insurers usually pay more for "hospital outpatient" procedures than they do for the same procedures performed at a physician's office or ambulatory surgical center. We have heard concerns that many acquisitions are designed to take advantage of these higher hospital-based payments even when there is no change in the care actually being provided. Congress and President Obama recently took steps to reduce this incentive to consolidate. The recent Budget Act requires that outpatient care provided at newly acquired or developed sites located away from a hospital's campus be billed to Medicare at the generally lower rates for physicians and ambulatory surgical centers. It is estimated that this measure will save the federal government $9 billion over ten years, and will save patients from being on the hook for higher out-of-pocket costs too.

We have also seen attempts to justify mergers on the ground that they will improve a company's negotiating position. Hospitals want to merge to get leverage over a dominant insurer; insurers want to merge to get leverage over a dominant hospital. Courts have long rejected the notion that "countervailing market power" justifies anticompetitive mergers or agreements. It is not at all clear that consumers win where a merger is justified solely on creating more bargaining leverage, the so-called "second 800 pound gorilla defense." As my friend and mentor Bob Pitofsky said about this argument some years ago, the antitrust laws "reflect a fundamental premise that consumer choice, rather than the collective judgment of sellers, should determine the mix of price and quality options available in the market place."[1] This is still true. Consumers do not benefit when sellers—or buyers—merge simply to gain

[1] Robert Pitofsky, Chairman, Fed. Trade Comm'n, Thoughts on 'Leveling the Playing Field' in Health Care Markets (Feb. 13, 1997), *available at* https://www.ftc.gov/public-statements/1997/02/thoughts-leveling-playing-field-health-care-markets.

bargaining leverage. Consumers benefit when there is entry, expansion, innovation and competition.

Effective antitrust enforcement extends beyond reviewing mergers. We sued to stop Michigan's dominant health plan from using most-favored nation clauses to insulate itself from competition, and saw policymakers in Michigan, North Carolina, and other states incorporate those principles into laws and regulations that outlawed anticompetitive MFNs. In Arizona, we stopped the hospital association from using its members' hiring practices to depress wages for temporary nurses. And in Texas, we told a dominant hospital that it could no longer use de facto exclusive contracts to discourage insurers from signing up smaller hospital rivals.

Some hospitals and physicians think that it is ok to reach anticompetitive agreements with their competitors so long as they don't agree on prices. It isn't. Just this year, we sued hospitals in Michigan to end their agreements to limit advertising in each other's markets. And we have regularly challenged group boycotts by providers and their trade associations directed at private and public insurance plans.

As antitrust enforcers, we must also be advocates for competition. The Antitrust Division and the FTC have worked together for many years to improve our understanding of how health care competition works. We have tried to share that knowledge with the public, including a new part of the Division's website that chronicles the Division's enforcement and advocacy efforts over the last 25 years. And, when necessary, we have tried to persuade state and local governments to avoid adopting—or to reform existing—rules that unnecessarily limit competition. For example, the Division and FTC have worked together, most recently in Virginia, to convince state and local governments that certificate-of-need laws "create barriers to entry and expansion, limit consumer choice, and stifle innovation."

There is more work to do. Many long-standing characteristics of health care markets—low price transparency, imperfect information about quality, high barriers to entry, and vulnerable consumers—can disrupt the competitive process. Antitrust enforcers must remain vigilant. We must continue to watch out for anticompetitive mergers or other agreements that exploit these characteristics. And we must ensure that incumbents do not stifle innovators working to provide low-cost care, whether through ambulatory surgical centers, telemedicine, or new types of providers. Competition has a critical role to play in promoting innovation and ensuring that American consumers have access to high-quality, affordable health care options.

Thank you again for allowing me to join you this morning.