March 10, 2014

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
601 New Jersey Avenue, NW
Washington, DC 20580

Re: Health Care Workshop, Project No. P131207

To Whom It May Concern:

The Council for Affordable Health Coverage and the National Coalition on Health Care are pleased to comment on several of the issues raised in the Federal Trade Commission's Notice of February 24, 2014 with respect to the Health Care Workshop. We co-chair the Transparency Taskforce, an ad-hoc multi-stakeholder alliance representing more than 30 companies, trade associations, research organizations, and patient and consumer advocacy organizations—entities which together broadly represent the customer side of the health care ledger. The views expressed in this letter are our own, and may not reflect the individual positions of our respective members or the Taskforce participants.

The Commission's review of antitrust policies in the health care sector is timely in light of several significant market developments, including the

- Increased utilization of high-deductible and Value Based Insurance Design (VBID) private health plans.
- Growing potential of information technologies to transform both the practice and business of medicine.
- Compounding effects of the rise in private health costs relative to household incomes.
- Compounding effects of the rise in commercial reimbursement for health goods and services relative to those paid by public Medicare and Medicaid.
- Growing expert consensus that unchecked market power has helped spawn both high prices and inefficient, supply-sensitive medicine.

Vigorous antitrust enforcement is necessary to support price-competition in U.S. health markets, but current policies fall well short of this goal. To address the twin challenges of inefficiency and high prices, we recommend changes designed to support price and quality transparency and increased data sharing.

1. Background

The U.S. health sector will take in roughly $40 trillion over the next decade alone.[1] Of that staggering sum, at least one-quarter [2]—and perhaps more than one-half [3]—will go toward services that are clinically unnecessary and, indeed, often dangerous.[4] Meanwhile, prices for common tests and procedures typically are 3-5 times higher in the U.S. than in other developed countries,[5] generally without yielding better outcomes.[6] This very low customer value (reflecting high prices and wasteful prescribing) has collateral effects on the macro economy, public finances and household living standards. By one widely used measure, health costs for the typical family of four rose from about 18 percent of the median family income in 2002 to 35 percent in 2013, a share that plausibly could exceed 50 percent early next decade.[7] The growing diversion of employee compensation into health benefits has contributed to the decline in the median household (cash) incomes and rising income inequality.[8]

Relevant factors include:

a. **Antitrust policy has not led to competitive provider markets.** In efficient markets, competition spurs enterprises to innovate in ways that benefit customers, thus raising labor productivity and improving social welfare. Producers in every industry aspire toward market dominance; but in most markets, supply- and demand-side forces are counterpoised, such that sellers can expand their market share only by improving customer value. When imbalances do occur, in theory, antitrust enforcement prevents hegemonic sellers from engaging in practices that discourage price-competition and innovation. This clearly has not happened in provider markets. While antitrust remains an essential tool, it has not been sufficient to assure needed levels of competition.

b. **Antitrust policy fails to distinguish between customers.** Confusion with respect to whose competitive interests antitrust should protect is deeply ingrained in the health care business framework. Because insurance socializes risks, the interests of patients and consumers often are not the same. For example, wasteful medical practices, in effect, pollute the risk pool, driving up premiums and out-of-pocket costs for the "silent majority" of relatively healthy consumers. Further sowing confusion is the

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[1] CMS Office of the Actuary, *National Health Expenditure Projections 2012-2022*, November 20, 2013, and authors' calculations.
[2] Institute of Medicine, "Better Care at Lower Cost: The Path to Continuously Learning Health Care in America," published on-line, September 2012.
[3] Kristen Bronner,"Supply Sensitive Care," *Dartmouth Health Atlas of Health Care, Center for the Clinical Evaluative Sciences*, January 17, 2007.
[4] Shannon Brownlee, "*Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer,"* Bloomsbury, 2008.
[5] International Federation of Health Plans, *2012 Comparative Price Report—Variation in Medical and Hospital Prices by Country* April 2013.
[6] Institute of Medicine, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, January 2013.
[7] Philip Longman and Paul S. Hewitt, "After Obamacare," *The Washington Monthly, January 2014.*
[8] Sylvester Schieber and Steven Nyce, "Treating Our Ills and Killing Our Prospects," *Council for Affordable Health Coverage*, June 2011.

segmentation of "payers," aka insurers, and "purchasers," aka employers. In general, payers confidentially negotiate volume discounts with providers off of list prices (for example, the hospital charge master) in what is essentially a wholesale business model; [9] purchasers generally buy health insurance—a retail product—on behalf workers (although self-insured employers may do both). In most markets, volume discounts expand producer capacity and create economies of scale, which then brings down prices for all. Provider markets, however, are supply sensitive: empirical evidence shows that providers use their discretion to prescribe (a function of physician licensure) to fill whatever capacity they have built.[10] Competition that expands unneeded supply may harm consumers and thus merits fewer protections than competition which incentivizes the adoption of identifiable, replicable best-value practices. (Intermountain Healthcare, a high-value provider, calls such optimization "the best clinical result at the lowest necessary cost." [11, 12]) Volume discounts that do not incentivize best-value practices reflect zero-sum cost shifting.

c. **Medicare's market power distorts private markets**. Medicare's efforts to control costs center on rate-setting, as defined in statute and implemented via regulation. This emphasis on price channels provider energies into boosting volume and intensity, which Medicare only lightly manages. To this end, hospitals invest heavily in sophisticated facilities and specialist medical staff, who then over-prescribe to both public and private patients. This capital-intensive strategy also compels hospitals to consolidate. Hospital credit ratings depend in large part (and increasingly) on market factors, such as market share.[13, 14] Among other things, market power allows hospitals to offset revenue losses from Medicare rate cutting by raising prices for private customers. While economists debate the prevalence of cost shifting—since, in theory, firms will always use their "reserve monopoly power"—hospitals claim it is widespread. [15] Cost shifting is explicit in Maryland's all-payer hospital rate setting process.[16] MedPAC estimates that Hospital Medicare margins will be -6.0 percent in 2014—meaning that more than 100 percent of hospital net profits are attributable to private patients.[17]

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[9] Kelly J. Devers, Linda R. Brewster, and Lawrence P. Casalino, "Changes in Hospital Competitive Strategy: A New Medical Arms Race?" *HSR: Health Services Research 38:1 Part II*, February 2003: pp. 449-469.
[10] John E. Wennberg, *Tracking Medicine: A Researcher's Quest to Understand Health Care*, Oxford University Press, 2010.
[11] John E. Wennberg, et al, "Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration**,"** December 2008, *The Dartmouth Institute for Health Policy and Clinical Practice*.
[12] Brent C. James and Lucy A. Savitz, "How Intermountain Trimmed Costs Through Robust Quality Improvement Efforts," *Health Affairs*, May 2011.
[13] William O. Cleverly and Paul C. Nutt, "The Decision Process Used for Hospital Bond Ratings—and Its Implications," *Health Services Research* (December 1984): 623. The authors characterize monopolies as ideal.
[14] Ron Shrinkman, "Standard & Poor's will revise ratings system for hospitals," FierceHealthFinance, December 12, 2013.
[15] For example, see on the American Hospital Association website: Margaret E. Guerin-Calvert and Guillermo Israilevich, "Assessment of Cost Trends and Price Differences for U. S.", *Compass Lexecon*, March 2011.
[16] Health Services Cost Review Commission, Minutes, Special Session of the Health Services Cost Review Commission, April 6, 2010.
[17] MedPAC Report to Congress: Medicare Payment Policy, March 2013: p. 56

d. **Medicare's efforts to promote value through integration present a challenge to antitrust policy.** A broad literature review suggests that care for the chronically ill—who consume a preponderance of health services and are disproportionately Medicare beneficiaries—is delivered most efficiently in large, vertically integrated health systems that control the care continuum. Business integration allows providers to reduce unnecessary care, for example, by eliminating duplicate tests and channeling patients to less expensive venues (for example, to 24 hour clinics rather than emergency rooms). In deference to Medicare's pursuit of care coordination, the antitrust agencies have issued a series of permissive antitrust guidelines dating to the early 1990s. FTC's 2011 guidelines with respect to Accountable Care Organizations (ACOs) permit previously independent hospitals, clinics and physician groups to collaborate in providing care for Medicare patients—and, by extension, to private customers as well. One result has been an uptick in hospital mergers and hospital acquisitions of clinics and physician practices.[18] Says one FTC working paper, "well-supported claims regarding clinical quality tend to be given more weight than other claims of pro-competitive merger effects."[19] However, economic theory suggests that providers will use their monopoly power to maximize profit. Empirical studies show that market concentration is associated with higher private prices and lower efficiency.[20, 21, 22] Consolidation generally has not improved care (largely because efficiency reduces revenues).[23] The government's pursuit of integration may stem in part from its monopsony power, which insulates Medicare and Medicaid from the adverse market effects of consolidation. Even if ACOs improve care coordination, without regulatory restraints, their effects on commercial markets are likely to be inflationary.

e. **Hospital market concentration fosters insurance industry concentration and may restrain insurers from aggressive efforts to improve efficiency.** Dartmouth Health Atlas groups the nation's 4,973 community hospitals into 3,436 Hospital Service Areas—an average of less than 1.5 hospitals per HSA.[24] About 10 percent of metropolitan statistical areas have just one hospital system.[25] The high level of provider market concentration, particularly among hospitals, may help to explain why as many as 94 percent of insurance markets are "highly concentrated." Insurers in

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[18] Accenture, "Clinical Transformation: Dramatic Changes as Physician Employment Grows," (2011).
[19] Joseph Farrell, David Balan, Keith Brand, and Brett Wendling, "Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets", Federal Trade Commission, October 2013
[20] Martin Gaynor, "Health Industry Consolidation," Statement before the House Ways and Means Committee, September 9, 2011
[21] James Robinson, "Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs And Cutting Them, Depending On Market Concentration," *Health Affairs* (July 2011).
[22] Jeffery Stensland, Zachary Gaumer, and Mark Miller, "Private-Payer Profits Can Induce Negative Medicare Margins," *Health Affairs* (April 1, 2010): 1045-1046.
[23] Claudia Williams, Robert Vogt and Robert Town, "How Has Hospital Consolidation Affected the Price and Quality of Care?" Policy Brief No. 9 *Robert Wood Johnson Foundation* (February 2006).
[24] Dartmouth Health Atlas 1999, "Appendix on the Geography of Health Care in the United States": The HSA designation reflected patterns of use according to Medicare enrollee ZIP Codes during 1992-1993. At the time, more than 51 percent of the population lived in HSAs where the localization index exceeded 70 percent. For the 2011 hospital count, see: http://www.aha.org/research/rc/stat-studies/fast-facts.shtml.
[25] Cory Capps and David Dranove, "Market Concentration of Hospitals," *Bates and White Economic* Consulting (June 2011): 2.

many local markets have few opportunities for engendering price competition and are vulnerable to retaliation. "Most favored nation" and other contracting practices reflect the ability of dominant providers to tilt the playing field in insurance markets, for example, by reducing or increasing a given insurer's market share. While monopoly insurance markets generally are associated with lower-than-average insurance rates,[26] empirical evidence suggests that dominant insurers in some markets have "unused" market power, which may be attributable to the fear of alienating providers.[27]

f. **High barriers to market entry and the essential status of hospitals and physicians in community health infrastructures create a political rationale for policies designed to insulate health providers, particularly hospitals, from the free interplay of market forces.** Barriers to entry are considerable: replacement costs for community hospitals typically run $200-500 million, while medical centers cost upwards of $2 billion.[28] The closure of a facility in many communities may represent a permanent loss in capacity as well as the loss of jobs. To inhibit destructive competition, 36 states operate Certificate of Need programs. FTC gives unusual large credence to the "flailing or failing" merger defense, in which the stronger partner is deemed to rescue a weak partner, thus preserving capacity that might otherwise close down. Only about 1.5 percent of non-hospital antitrust cases feature this defense, but more than half of hospital merger cases do.

2. Comments and Conclusions

The facts and issues outlined above support a recalibration of antitrust policy. Key developments include: costs that every year are compounding off a higher base relative to median household incomes; consumer familiarity with online comparison shopping; high levels of price variation within historically localized markets; the nascent adoption of health plan designs that reward consumers for traveling outside local provider markets; and extensive research documenting that competitive markets are associated with higher value.

a. **Price and quality transparency can help to control costs for the "silent majority" of relatively healthy consumers.** Eighty-one percent of health spending is consumed by the 20 percent of the population that is most seriously ill and injured.[29] Insurers and health care providers spread these costs onto the healthier 80 percent via premiums and prices (the latter, for example, reflecting cost shifting by hospitals). Historically, insurance has inured relatively healthy consumers from high provider charges, thereby fostering a preference for convenience over cost. Such a preference localizes health markets and enhances provider pricing power. For example, in a 2008 study examining a

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[26] Glenn A. Melnick, Yu-Chu Shen and Vivian Yaling Wu, "The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices," *Health Affairs*, September 2011.

[27] Chapin White, Amelia M. Bond, James D. Reschovsky, "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power," HSC Research Brief No. 27, *Center for the Study of Health System Change*, September 2013.

[28] Bruce Cryan, "Hospital Capital Investment in RI (2008)" *Rhode Island Department of Health*, February 2010: 6.

[29] Kaiser Family Foundation, Kaiser Fast Facts, published on-line: http://facts.kff.org/chart.aspx?ch=1344

2000 merger of hospitals located 2.5 miles apart in Berkeley and Oakland, California, FTC found that the merger had allowed the smaller of the two hospitals to raise its prices by 28.4 percent to 44.2 percent (for different insurers). This was despite the presence of 17 hospitals within a 20-mile radius.[30] Enhanced pricing power is reflected in sometimes extreme price variation for routine tests and procedures. [31, 32] More recently, however, the increased adoption of high deductible health plans, which expose consumers to price variation up to the deductible limit, and VBID plans has broadened the geographical "footprint" of markets for non-emergent, schedulable tests and procedures. For example, many consumers are willing to travel tens of miles in order to save, say, $2,000 on a colonoscopy. Separately, consumers have become more familiar with online comparison shopping. In many metropolitan areas, the new willingness of consumers to comparison shop will create needed price competition across much wider geographic areas than historically has been the case.

To empower mobile consumers, we recommend the following:

i. Hospitals, testing centers and ambulatory clinics should post the average amounts collected over a two year period from both the insured and uninsured for the 100 most common tests and procedures, in a manner conducive to comparison shopping.

ii. Health care providers should be forbidden from engaging in anticompetitive contracting practices whose effect is to suppress price-sensitivity. In the 2011 ACO guidelines, FTC identifies several such practices, but merely advises providers proposing to combine "to avoid" them.[33] (While FTC does not have the authority to regulate such practices after a merger occurs, DOJ does.) Suspect practices include "anti-steering," "anti-tiering," "guaranteed inclusion" and "product participation parity" clauses.[34]

iii. In addition, we recommend prohibiting "gag clauses," in which dominant providers forbid insurers from including their prices in online comparison websites for policyholders. At a minimum, such prohibitions should be a standard condition of merger approvals.

b. **Commercial entities, including insurers and data analytics firms, should have greater access to both public claims and private quality data for the purposes of managing care and constructing effective online comparison-shopping tools for**

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[30] Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," Federal Trade Commission Working Paper No. 293 (November 2008): 20-26.
[31] Paul B. Ginsburg, Wide Variation in Hospital and Physician Payment Rates—Evidence of Provider Market Power," Research Brief No. 16 *Center for Studying Health System Change* (November 2010): 5-6.
[32] Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, March 16 2010: 3-4, 17-40.
[33] *Op. Cit.*, Department of Justice and Federal Trade Commission (2011): 10-11. See also the Massachusetts Attorney General report: 40-41. The Coakley report provides rare examples of such restrictive language.
[34] Paul B. Ginsburg, "Shopping for Price in Medical Care," *Health Affairs*, Web Exclusive, vol. 26, no. 2 (February 6, 2007),p. w213.

consumers. Relatively healthy consumers, who are mobile and price sensitive, need comparison shopping tools capable of showing, for example, the often inverse correlation between quality and cost. Effective comparison-shopping tools must take into account such complexities as risk-weighting and efficiency, which requires sophisticated data analytics.

To this end, we recommend:

i. Program rules should not prevent public program claims data from being made available to commercial entities, including insurers, comparison-shopping vendors and analytics consultancies, even in the most highly concentrated markets. Such data is as relevant to the health and well being of private consumers as it is to Medicare and Medicaid beneficiaries.

ii. Antitrust rules should expressly encourage health plans to share privately collected quality data. In general, data becomes more reliable the larger the sample size.

c. **The antitrust agencies should investigate potential remedies—both antitrust and regulatory alternatives—designed to support competition among insurers in the realm of care management.** The most expensive patients, particularly the five percent who account for roughly half of health expenditures, are neither mobile nor price-sensitive. For these populations, competition among insurers is essential. We note that insurance is a retail product, with transparent, capitated prices, whose underlying costs are amenable to efficiency gains. Effective competition among insurers requires not only better data, but protection against unwarranted price discrimination by market dominant providers. When used as retaliation against insurers for aggressive care management, provider market power is profoundly anticompetitive and anti-consumer.

Thank you for this opportunity to comment. Should the Commission find it worthwhile, we would be please to present in the workshop with respect to any of the aforementioned issues and recommendations.

Sincerely,

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