

FTC and DOJ Host Workshop Examining Health Care Competition

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The Federal Trade Commission (FTC) and the **Antitrust Division of the U.S. Department of Justice (DOJ)** held a public workshop on February 24–25, 2015, to examine recent trends and developments in health care provider organization and payment models, and their potential effects on competition in the provision of health care services. Participating agency officials, industry representatives and experts covered a wide range of topics. A primary theme that emerged is that while it is too early to determine the effects of many recent market innovations, the FTC and DOJ evaluate new provider and payment models for their adherence to competition principles, effect on cost of care, access and quality, and avoidance of market power. The workshop agenda and speakers can be found on the [FTC website](#).

FTC Chairwoman Ramirez and Assistant Attorney General Baer Emphasize that Innovation in Provider and Health Insurer Markets Must Comply with Antitrust Laws

FTC Chairwoman Edith Ramirez confirmed that focus on health care competition remains a top FTC priority. She said the FTC has long held that consumers benefit from competition in health care markets—just as they do in other markets—and that recent industry developments and passage into law of the *Affordable Care Act (ACA)* have not altered this belief. Ramirez reiterated that the goals of antitrust law are fully consistent with the goals of the ACA and health care reform. She also said the U.S. Court of Appeals for the Ninth Circuit’s recent decision upholding the agency’s challenge to an Idaho hospital’s acquisition of a physician group affirmed the FTC’s view that any procompetitive benefits resulting from integration between the parties could have been achieved short of a full merger.

Ramirez noted that the FTC recognizes that *accountable care organizations (ACOs)*, alternative payment models, new network designs and other innovations have the potential to lower health care costs and improve quality, and the FTC will continue to examine them. She referenced a growing concern about provider consolidations, not only from horizontal mergers but also from mergers

between firms in non-overlapping product or geographic markets. As examples, Ramirez cited acquisitions by urban hospitals of suburban hospitals, and vertical consolidations. She urged industry participants to take heed of competition principles and abide by antitrust law when innovating with new models for delivery of care.

U.S. Assistant Attorney General (AAG) for Antitrust Bill Baer also stressed the importance of vigilant antitrust enforcement in health care markets. “Because health care is fundamental to our lives,” he said, “we share an interest in maintaining and fostering competitive markets that will keep prices in check, improve quality and spur innovation.” Baer remarked that innovative health plan designs, such as narrow and tiered networks, “encourage providers to compete on price and quality” and “have the potential to drive competition and benefit patients.” He said that DOJ understands the potential benefits of these responses to health care reform and will focus its resources on identifying and remedying abuses of market power, especially in provider contracting practices.

Baer also noted that an additional area of concern for the agencies is the trend in vertical integration shown in hospital acquisitions of physician practices. “Transactions that promise to improve the delivery of care and that pose no threat of increased prices or other competitive harm should be allowed,” he said, but the agencies “stand ready to take appropriate enforcement action against transactions that harm competition.”

Provider Network Design, Contracting Practices and Regulatory Activity

The first workshop panel discussed narrow and tiered provider networks, noting the increased prevalence of these networks after enactment of the ACA. Panelists attributed much of the increase to insurance exchanges, characterizing them as ideal for narrow network plans because out-of-pocket cost is so important to consumer decision-making on the exchanges. Almost half of all networks sold through exchanges are narrow, according to the panel.

Panelists said narrow and tiered networks have potential to lower costs because they enable insurers to shift volume to lower-priced providers, negotiate lower prices and incentivize providers to contain costs. Panelist Paul Ginsburg said tiered networks, which offer more provider choice than narrow networks but also designate which providers cost less to enrollees, may become more popular. Narrow networks require enrollees to choose providers in advance, but tiered networks allow provider choice at the point of service.

Panelists stressed the need for consumer education and network transparency, noting that consumers lack basic understanding about provider network design and are unprepared to make informed decisions. Industry standards for reporting on network adequacy was said to be weak and often based on health plan self-reporting. Panelists urged more consumer protection measures, including remedies for consumers who rely on erroneous provider directories and robust minimum standards for network adequacy.

Panelists said new provider network structures may raise competition concerns if they increase provider market power and enable bargaining for higher prices or potentially anticompetitive contract provisions, such as anti-steering, anti-tiering, bundling, carve-out or exclusive dealing clauses. Panelist Fiona M. Scott Morton also pointed out potential efficiencies from provider consolidation, including cross-subsidization of business lines and increased costs savings from economies of scale.

Health Insurance Exchanges

Another panel addressed ACA-created health insurance exchanges, which are designed to expand consumer access and encourage insurer participation. Health insurance exchanges began only with the 2014 enrollment period; panelists said they have little data at this point upon which to draw conclusions but recognize trends in consumer behavior and the insurance market.

One such noted trend is that consumers who purchase health insurance through the exchanges are very price sensitive. Plans that offer products in the lower-priced segments control a larger portion of the market than more expensive plans. Panelist Keith Ericson said consumer price sensitivity depends greatly on age; he found that consumers older than age 45 are about half as price sensitive in these markets as consumers under age 45.

Another trend cited by panelists is that in markets with health insurance exchanges, new entrants quickly obtained significant market share if they charged a lower price. Panelist Pinar Karaca-Mandic observed that the drive for enrollments and market share may lead some insurers to charge premiums that are too low, and noted that this may be why a Minnesota exchange entrant gained significant share, only to later exit the market. Ericson said consumer inertia may lead to insurer strategies to charge very low prices at the entry stage. Insurers may offer low introductory prices, then later raise prices because consumers are unlikely to switch plans, especially because enrollees who do not initiate plan changes are typically defaulted into their incumbent plan in following years.

Panelists said the impact of health insurance exchanges differs significantly by state, possibly because of state-by-state differences in exchanges, some of which are federal-based, while others are state-based. As to the latter category, some use an active purchaser model (state selects and negotiates with participating insurers), and others use a clearinghouse model (state accepts any health plan that meets certain published criteria).

Accountable Care Organizations

Another panel focused on ACOs. Officials from the Centers for Medicare & Medicaid Services (CMS) reported significant increases in the number of providers seeking to participate in ACOs, substantial savings achieved by ACOs, and positive responses from the beneficiaries of ACO care. The officials said that CMS aims to promote seamless coordinated care through ACOs, grow participation in the program and gradually shift more organizations to undertake higher levels of risk. They also observed that experience shows that “one size does not fit all” in terms of ACO operational risk and payment structures.

Two panelists focused on the effects of Medicare payment policy on competition between networks of independent physicians, on the one hand, and physicians employed by hospitals and health systems, on the other hand. One panelist said that Medicare’s policy of paying more for physician services rendered in hospital outpatient provider-based (HOPB) facilities than physician services rendered in free-standing facilities was driving independent physicians into the arms of health systems that convert physician offices to HOPB facilities. One commentator added that Medicare incentive payments for both electronic health care record meaningful use and the Physician Quality Reporting System program are also pushing independent physicians to health systems. As a result, hospital-employed physicians may receive more reimbursement for providing the same services than do independent physicians. One panelist commented that this trend makes it more difficult for independent physicians to compete. However, presumably payers would choose to contract with the lower-cost provider of the same services in a competitive market, assuming no difference in quality exists.

The consensus among CMS, industry and expert panelists was that although ACOs take a wide variety of forms, keys to their success include strong clinical leadership, a culture of collaboration between leadership and physicians, communication and transparency among the providers, a redesign of common practices, and effective information technology and analytics. Panelist Kristen Miranda said having a sound financial model is a necessary but insufficient foundation; an ACO must also have structures to align incentives and effectuate change “on the ground” in the actual treatment of patients. Panelists recommended that in evaluating the competitive effects of ACOs, the FTC and DOJ continue to use the guidelines they adopted in their 2011 policy statement, but commented that the guidelines may need to be revised after a few more years of observation.

Alternatives to Traditional Fee-for-Service Payment Models

Alternatives to fee-for-service payment models comprised a topic for another panel. Panelists remarked that consumers across markets pay very different amounts for health care services, without regard to variations in the quality care that is received. The ensuing discussion was wide-ranging, covering many different types of payment models—variations of traditional fee-for-service arrangements, bundled payments, global payments, pay for performance, patient-centered medical homes and other approaches. Most payment reform methods fall into one of three categories: upside risk only to providers, downside risk only to providers and shared risk arrangements. All are intended to align incentives to improve quality and slow the rate of medical spending growth. Health plan panelists spoke in some detail about the elements of their respective risk- and value-based programs with providers.

Panelists observed that cost-savings from alternative models may be easier in the early years after formation because of “a lot of low-hanging fruit,” but that savings three to five years out will depend on aligning incentives with consumers over quality and cost, advancing preventative care and eliminating great variability in expensive treatments, among other things. Panelists also said that that government has a role in helping to shape outcome and quality metrics and ensuring competitive markets.

Trends in Provider Consolidations

The workshop panel on trends in provider consolidations did not focus solely on horizontal merger issues. Panelists discussed other types of consolidations, including those between hospitals and physicians, between providers in separate geographic markets, and between health plans and providers. Speakers discussed variants of consolidation between a hospital and physician practice group, including those without economic integration (such as a marketing arrangement), with limited economic integration (salaried employment or salary guarantees but no significant clinical integration) and with clinical integration (including a clinically integrated network). Goals for such transactions identified by panelists included higher physician incomes, improvements in care processes and quality, better sharing of clinical data and preparation for an ACO arrangement. This panel also discussed the FTC’s recent Idaho litigation and the record in that case regarding the efficiencies and quality improvement potential from the transaction.

Another speaker discussed her economic theory concerning “cross-market consolidations,” *i.e.*, those between providers that do not compete in the same geographic market. Panelists pointed to recent evidence that suggests that cross-market mergers tend to lead to higher hospital prices, which, according to panelists, could be the result of improvements in quality, changes in service or patient mix, or a change in bargaining skill or ability to bear risk. Panelists suggested that this theory is still new and in need of further development before an enforcement action would be advanced under this

theory.

Payer-provider consolidations are another vertical consolidation that has become more common. According to panelists, such transactions can be driven by the provider's attempt to position itself to manage risk-based contracts, become an ACO, engage in improved population health management or, potentially, enhance its bargaining position with payers, which can raise competition concerns.

Conclusion

For providers and health insurers and their counsel, a number of important considerations should be taken from the workshop:

- The mere fact the FTC and DOJ collaborated on a two-day program focused exclusively on competition in delivery and payment in health care services, with remarks by the chairwoman and the AAG for antitrust, underscores the high importance and close attention the antitrust agencies place on competition in health care markets.
- The FTC and DOJ categorically reject any argument that antitrust enforcement should take a back seat in health care because of provisions in the ACA that appear to endorse the benefits of integration and create incentives for collaboration.
- All industry participants must closely evaluate the antitrust implications of potential transactions—not just with nearby direct competitors, but also in vertical arrangements with other providers or health insurers.
- Providers must evaluate whether restrictive clauses in network contracts, such as “anti-tiering” and “anti-steering” provisions, raise undue risk of charges of anticompetitive effects.
- Health insurers that market narrow and tiered network products, and their in-network providers, should be cognizant of potential market power allegations that could arise from these arrangements, and should devote resources to consumer education about these products.

The FTC says it will archive the webcast for the full two-day workshop and post the written transcript on its website, enabling the public to learn in-depth the details of each panel discussion.

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