2013 MacEachern Symposium:
On a Collision Course? Health Care Integration and Antitrust

Northwestern University, James L. Allen Center
June 5, 2013

SPEAKER: JOSEPH MILLER
General Counsel, America's Health Insurance Plans

"Why Providers Should Welcome Antitrust Enforcement"

Allen Now we're going to hear from the health plans' point of view. And our presenter is Joe Miller, who is the General Counsel of the America's Health Insurance Plans Association, known effectively as AHIP. Prior to joining AHIP, he served in the Antitrust Division of the Justice Department, working with Josh Soven, our earlier speaker, where Joe oversaw enforcement and competition advocacy in a wide variety of industries including health care and insurance markets.

Joe is a graduate of the George Mason University School of Law and earned an undergraduate degree in economics from Emory University.

Miller Thank you. [Audience applause.] So thanks for having me, and thanks to David Dranove for inviting me. I'm pleased to be here to discuss these topics.

So I'm from AHIP. We are the trade association for health insurers. I've been there about three years. However, from 1991 until three years ago I was an antitrust lawyer. I started at the Federal Trade Commission. I spent some time in private practice and then 12 years with the Justice Department. So for most of my professional career, I was in antitrust enforcement; some litigation, but mostly administrative enforcement of antitrust law.

The central organizing principle of antitrust law – it's an article of faith as well as a tenet of law – is that markets produce consumer welfare. That's what's important, that's where we start, and that's where antitrust enforcement in provider markets starts as well. Competition needs consumer protection. That's what it's all about.

Since I moved to AHIP, my perspective has been, let's say, broadened. The world of health care policy is driven by another central organizing principle, and that is regulatory oversight: command and control is what drives health policy. They're really divergent views. I didn't properly or fully appreciate or understand it until I started working in health care policy full time. There's a difference and a chasm there that needs to be understood.

My thesis is that providers, although they may not like antitrust enforcement, should appreciate it because it acts as a stop, as a bulwark, against something that's worse, which is more pervasive regulation. Further regulatory oversight health care providers would be undesirable.

Since there are some economists in the room, I'll put this is in terms of alternatives. We can't call something good or bad except in comparison with something else. So let's start with why I think antitrust is not that bad as an alternative.

We heard just the litany of what the FTC's been up to. It's not that long of a list. As an example, AHIP filed an amicus brief in the Court of Appeals in the ProMedica case. That was a four-to-three merger in Toledo, Ohio. We didn't do it because there was anything doctrinally interesting about the case or because Toledo is a market that should command attention above and beyond other health care markets.

It's because it's the first time in more than a decade that a Court of Appeals has had a shot at a hospital merger. That's stunning: the first time in more than ten years that any Court of Appeals in the United States has gotten to rule on a hospital merger. There are lots of reasons for that. There are strong incentives not to litigate with the FTC, and the DOJ, for inside-baseball reasons, has withdrawn from hospital merger enforcement, although it still investigates and litigates other hospital and provider cases. So there are good reasons for why we don't see many get into the Court of Appeals, but one of them is that there simply aren't that many cases. And so when one did get to the Court of Appeals, we thought that the larger market power is such an important part of health care policy, and such an important part of the cost problem, we took the opportunity to offer our views to the court.

So in a four-to-three hospital merger in a city that's not otherwise the center of health care policy discussions, we filed an amicus brief. If you're looking to see the brief, it addresses some of what we're talking about here today. I recommend it to you; it's on our website. It gets at some of the points we're talking about, makes the point that integration in and of itself is neither good nor bad, but it has economic effects, and the effects can sometimes be bad. The effects, if they're bad, can't be justified by the Affordable Care Act as pushing providers toward consolidation. Other health policy considerations are also discussed in the brief, so I'd recommend that to you.

The AHA study identified 360 hospital transactions in 2007. The FTC has challenged, by my count, four. There may be good reasons: a lot of that activity may have been in places where there's no competitive overlap, so there's nothing really to investigate. But if we're talking about that level of enforcement activity, we come up with just a few interesting cases:

ProMedica and St. Luke's. And by the way, I think St. Luke's is the one that's going theoretically beyond where the Commission has gone before.

I think Josh talked about where the FTC tends to challenge. It's where the cases are relatively easier to bring and to explain to a court. There's a difference, I would think, between the modern learning from Evanston and where the case law is, which pushes you back toward the Elzinga-Hogarty type, thinking about geographic markets. It just means that you're explaining this to a generalist federal judge; you've got a pretty good challenge ahead of you if you're an enforcer because the theory of competitive harm isn't well explained by the cases that they must rely on for precedent. So those are some of the reasons to explain and understand why the FTC is focused on those sorts of cases – but it doesn't mean that that's where the potential harm is going to be the greatest, so that's something to pay attention to.

So 360 hospital transactions, about four challenges; it's a pretty good ratio. That, I think, is pretty well understood. There's something that I think is not as well understood, or at least not as frequently discussed. Starting in the mid-1990s, providers asked for and received a series of advisory opinions from the Federal Trade Commission regarding clinical integration. If you really want to torture yourself, you can read them end-to-end. They tend to be about 35 pages, single-spaced, and they are dense. It's not light reading.

What most all of them talk about is whether there's been sufficient integration under the law to get over the *per se* rule and to be evaluated under a rule of reason. That's what they talk about. So I don't know how many letters there are – 12, 15, something, a fair number of them – almost all the clinical integration letters are about whether there's sufficient integration to be evaluated under a rule of reason.

That's really astonishing. There's very, very little discussion of what should be the important antitrust issue: whether there's an aggregation of market power. Some of the letters go as far as to say, "We recognize that there's a market power issue." Full stop. That's it. You know, sometimes they'll say, "Also we recognize it is a market power issue, and if it comes to fruition, we're still here; we will check in every once in a while." But in reality, that doesn't happen. Once you've got the integration, once the integration happens, there's a really, really deep reluctance to go back and try to untangle that. Now that's not only in health care and with providers, but generally the reason that merger review is prospective is because once assets are integrated, it's very difficult to do anything about it as a practical matter.

You have providers coming one after the other to the FTC, asking for advice, clinical integration advice, and getting it as to whether something passes the *per se* test or not, but the market power issue goes unaddressed.

The providers are not required to ask for the FTC's views on clinical integration. It's not mandatory. If you're going to ask permission from the government for something for which you do not need their permission, yet you still go – and they go, I think, because they're getting a pretty good answer – that's really pretty good. If you are a provider, I think you ought not to be complaining too vociferously about the Federal Trade Commission, because the enforcement is a pretty light touch. And I say that in reference to the market power problems that I think exist from the consolidation of providers.

Again, some of the cutting-edge research was done here at Northwestern. If you're looking for a place that draws it together in an accessible way, look to AHIP's website. There's something called ahipcoverage.org that collects the policy-oriented literature on provider market power. So on the whole, from the perspective of the provider community, FTC and DOJ enforcement is not that bad.

What is the alternative? What is the regulatory alternative? My view is that it's pretty undesirable. Let me give you some examples from my experience, and then from the Affordable Care Act as it applies to the health insurance industry, to try to provide perspective.

Paul Ginsburg is a Ph.D. economist. He runs a think tank called the Center for Studying Health System Change. I will assert to you that he is well regarded in health policy circles. In the world of health policy, I will assert that he's very well regarded. People listen to him. He publishes in the sort of journals that people read when they're trying to do this sort of work, and he's a thoughtful guy.

We had him to a summit we put together on ACOs last month, and I asked him to come to talk about consolidation trends. He's done some research and can speak to this with some data. He was discussing some remedies to market power problems and discussed some of what David discussed: preference pricing, tiered networks, all of which makes perfect sense, and it's all very polite discussion.

As he got to the end of it, he talked about Maryland, which is direct rate setting by the government for providers. Every hospital in Maryland has its rates set by the state. He said this just as if it were another on a tick list of things to consider. I was sitting up there; I was moderating that panel; I was on the podium with him, and I tried to, you know, keep my jaw from dropping because it just was – to somebody from an antitrust background, that's incredible. That's just not something that you discuss in polite company. To somebody who's in the health policy world, it's, you know, just another possible remedy among many. I actually asked him about it and he thought of direct rate setting as a kind of a little stick to add to the choice set.

To which I said that instead of a stick it sounds more like the Sword of Damocles.

So that is discussed in polite company. What's going on in Maryland strikes me as Woodrow Wilson's dream come true: a panel of experts, completely disinterested, deciding what's right for the public good, and then having the power of the government to enforce it.

It provoked no discussion of first principles as to whether this is a good or a bad thing. And I would again assert to you in a room full of antitrust professionals that it's just not something that's discussed. It's beyond the pale. But in the health policy world, it is not even remarkable. The idea of direct price control is considered one of multiple options. If I were in the provider community, that would make me concerned. Perhaps it's not troubling because at that point it's still kind of a theoretical discussion. So let's turn to some more real-world examples of what price controls look like as applied to health insurance. We get this from the Affordable Care Act.

There are two provisions of the ACA I'd point you to. One is rate review. This is a federal provision in the Affordable Care Act that makes insurers justify "unreasonable" rate increases. It's a shaming mechanism: "If your rates go up more than 10 percent, tell us why, put it on the website." In addition to that, the federal government is offering states money to bolster their rate review programs. And some states have what's called prior approval, which means insurers can't implement their rate until they get somebody from the government saying OK. Sometimes states have a "file and use" system, meaning that insurers have to publish the rates ahead of time, and there may be some political backlash, but that's something as an insurer you decide to live with or negotiate over, but that's where that is.

The federal rate review provision, by itself, is fairly mild. In terms of price control, I think the concern is that it's just the first step. It goes: "Well, we tried rate review; it didn't work; it didn't contain costs. Now we're going to have to go at this with more direct control." That's pretty troubling.

So rate review I think of as the less intrusive of the price-capping, price-control mechanisms. It's there, but it doesn't have much bite.

The second ACA provision, however, I think is not as well understood and is much more pernicious. It's the federal MLR, or Medical Loss Ratio. I'll refer you to Professor Scott Harrington's paper. He's a professor at Wharton. He's written a very insightful paper in the journal *Inquiry* that lays all this out in a lot of detail.

What is the MLR? Insurers must spend 80 to 85 percent of premiums on medical costs, on medical expenses or [inaudible, 23:30], so it depends on the

size of your group if you're between 80 and 85 percent. The money that's not spent in those ways is rebated to your customers. So again, to an antitrust lawyer, to an antitrust economist, who thinks about markets as providing consumer protection and markets as providing sorts of – it's not just to control costs. This is just a showstopper.

The stated purposes of the MLR are transparency, consumer value, and efficiency. So this is the MLR's regulatory approach to something that markets should be doing, right? Transparency, consumer value, efficiency delivered in the form of a law and in the implementation of regulations saying exactly how you must spend the money you're taking in, and where it must be spent going out.

So what does not count in those categories of MLR? If you're a health plan, anything. It's a little facetious, but not that far off – anything that can help control costs: utilization review, fraud detection (except for the monies that you actually recover, so fraud detection efforts that are not 100 percent successful count against you), provider network formation (including what David said about tiered networking) – innovative sorts of things like that count against you in the MLR.

So what does this mean for insurers and customers? It's the nature of insurance: there's going to be statistical variation in claims experience that makes it difficult to predict with precision what your medical expenses will be. There's trended, there's medical trend, there's burden of illness, there's the pool that you're going to be insuring that is going to be changing over time; it's going to be changing in a big way in 2014. There's a lot of volatility, so when you're pricing your products right this minute to be selling in the open enrollment period coming up in October, it's a big, big question mark as to what pool you're going to be insuring. And, of course, if you think about insurance, it's the average cost of care of that particular pool, so it's a lot of guesswork because there are a lot of moving parts to accommodate and consider. If you guess wrong and you charge too much relative to your medical expenses, that money is rebated. If you charge too little and you do it repeatedly, you're out of business.

So the MLR is not leaving a lot of room for error. The places where I think you want health plans to be spending money is on innovation. I mean, again, I think David and I agree that there's a lot that health plans could and should be doing to help innovate, but it's really discouraging if you're under this sort of a regulatory constraint.

Innovative delivery models, ACOs' population health management, risk sharing of different sorts with providers – you know, all that is necessary to get the networks together with willing providers to do anything creative. You need the IT to support it. All of this counts against you in the MLR calculation.

One other item I'll put in front of you is the high-deductible health plan, the nature of which is to get consumers to spend their own money in order to hold costs down. That, by definition, is going to be on the wrong side of the MLR, or at least that's what they're saying.

So cost control and innovation, they take a hit from the MLR. Why is it a big deal? Well, whatever the proponents say about it, why is such a top-down regulatory remedy the right one, the right one here? They argue that health plans have excessive profits and administrative expenses. That's the reason, so it's explicit as a profit-lowering device. That's the regulatory approach. It doesn't have to be as crude as the Maryland approach, which is, "I will decide what you get paid." It can be a cap of some sort that provides unintended consequences regarding incentives. That doesn't mean that you're out of business, but it does mean that you're constrained in ways that you ought not to be constrained.

So the history is covered in Harrington's paper. What are the historical MLR levels and what are the profit levels that require this sort of – I think it was a Draconian approach? From 1965 to 2010, the loss ratio across all commercial insurance business was 88 percent. Profit margins were 2 to 4 percent for health insurers. It's a little higher for publically traded, for-profit companies, a little lower for non-profits, but you're in that range, 2 to 4 percent profit margin. That is what drew this sort of remedy..

And so again, to bring it back to the theme, if you're in a provider market, you're a hospital, antitrust enforcement is stopping a regulatory push in your direction, I would think that would be an OK way to go.

Why do we think that this regulatory approach is possible? I think it's already starting. In Maryland, and then in Massachusetts, which are more traditional regulatory kinds of environments, there are discussions of a "global payment system," which is a polite word for "the total amount of money we're going to spend on this is going to be decided at the state level."

You see an increased emphasis on transparency. Medicare just released a whole bunch of data. Transparency is a word in health policy that sounds nice, and it's hard to argue with, but it makes my antennae go up because usually there's something that follows behind it that's a little less benign. So I think a more forceful regulatory approach could be coming.

In an atmosphere where regulatory approaches are acceptable – and competition policy, I think, is one value among many for regulators, and really not that important of a one – I think providers could find it useful to make the argument that markets are doing their job, and that markets should be protected.

Now I want to pause for a minute and ask, what does it mean to say a market is "doing its job"? I think David said, you know, "Where's the evidence that competition is producing benefits?" He may not have said it exactly in that way, but that's what I heard. And again, I think there's lots of evidence that provider market power has led to increased costs for health care consumers.

Beyond that, I think two examples that are most noted in the news – Sutter in northern California and Partners in eastern Massachusetts – those are both provider systems that are reported to have substantial amounts of market power. They're both also talked about as having antitrust inquiries currently under way. It may not be fun to answer them, but if the next step beyond them is more direct MLR-type regulation, I think it's probably useful for them to say, "Hold off; let's see where this goes." Competition, I think, does provide benefits, and we should welcome antitrust enforcement if it holds off worse kinds of regulation.

So I think we still have a few minutes for questions. I'd be happy to…

Allen Questions?

Woman I'm curious: what would you think additional price transparency consumers could play, and what role the insurer should play in getting that information out there?

Miller Sure. So it can be helpful, although I think it's helpful in a relatively limited way when you're talking about health expenditures overall. Part of the idea behind ACOs and population health management is that the bulk of the medical spending is in what's called an inelastic part of the demand curve. So the top – I don't know exactly what it is, the top 70 percent of health care spending – is somewhere that incentives are provided by greater transparency, and choice, I think, won't make that big a difference on the margin.

The idea behind these programs is that the next chunk of people who are potentially helped by staying out of the hospital – to treat chronic diseases, things of that sort, if you have emphysema, if you have kidney disease, if you've got diabetes – these things are treated outside the hospital, and you're going to aggressively lower cost overall. And therefore it's smart money to spend, and that's where incentives end up being important.

I think in the consumer-directed health plans, it can make a difference, although it tends to be for the sorts of services that are, in the big picture, a little less costly than the months-long stay in a hospital.

Now it doesn't mean that that's not a good thing; it is a good thing, and you need the information to be provided in a rational way. I think we ought to be realistic about the total effect that can have. The thing about that is for any sort of significant health care episode, you're likely to hit your deductible and co-pay quickly. And that's where the incentives are, right? Such that once you're past that point, the incentives to choose among providers for efficiency reasons diminish.