SQUIRE PATTON BOGGS

EXAMINING HEALTHCARE COMPETITION: A REPORT FROM THE FTC/DOJ WORKSHOP

The US Federal Trade Commission (FTC) and Department of Justice (DOJ) recently held the second of a series of workshops designed to enhance their understanding of the competitive implications of a rapidly evolving healthcare industry. The two-day workshop summoned experts from government, academia and business to address some of the industry's most significant developments. There were robust presentations on accountable care organizations (ACOs), exchanges, emerging provider network designs, alternative payment models and provider consolidation. Following the presentations, there were spirited question and answer sessions in which representatives of the FTC and DOJ had the opportunity to press the speakers on certain issues. The agencies continually stressed the importance of this exercise to the execution of the antitrust laws. They proclaimed that antitrust law is consistent with healthcare reform and that they are committed to preserving competition in the midst of the changing landscape.

The FTC maintains a website that contains complete information about the workshop, including presentation slides and video recordings. Transcripts will also be made available. The agencies invite interested parties to submit public comments for the workshop until April 30, 2015, and instructions for commenting are on the website. For your reference, please find a summary of each of the discussion topics below.

Tuesday, February 24, 2015

Opening Remarks

- Edith Ramirez, Chairwoman, FTC

At the outset, Chairwoman Ramirez pronounced that healthcare is one of the top priorities on the competition agenda, and underscored its importance to our economy and the well-being of our nation. After setting the stage, she declared that vigorous competition provides consumers with lower costs and higher quality of care, and she affirmed that the goals of competition law are consistent with the goals of healthcare reform. She particularly referenced the Ninth Circuit's recent decision in the St. Luke's case to bolster her claims, stating that the merger would have led to higher costs and that its benefits could otherwise be achieved. In her words, the "goals of healthcare reform are consistent with but do not supplant the goals of competition law."

Chairwoman Ramirez assured the audience that she understands the complexity of the issues that the healthcare industry is facing and appreciates their efforts to adapt to the reform. She stated that the workshop was an invaluable opportunity to better understand these concerns, and she believes that it is vital to stay on top of new developments and their competitive effects. She concluded by stating that industry knowledge is integral to sound competition enforcement policy.

Framing Presentation

- Ezekiel J. Emanuel, MD, PhD, Chair, Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania

Framing the discussions that would take place throughout the workshop, Dr. Emanuel proclaimed that this would be an exercise in making predictions, which is inherently difficult. He explained how the healthcare industry is going through more structural change than at any point since 1910. He further stated that healthcare is by far the largest industry in the country and, in fact, is the fifth largest economy in the world. Dr. Emanuel described the healthcare market as one with wide variability in costs, quality of care and profit. To reduce cost and improve quality, he asserted that the system will need to reduce emergency room use, hospital admissions, specialty care utilization, price variation among providers of the same service, and unnecessary tests and treatments. He claimed that the threat of an antitrust suit can influence decision-making moving forward.

Dr. Emanuel claimed that hospitals and physicians merit the most scrutiny because they are the two highest grossing players in the market. He believes that they are ready to transition from pay-for-service to pay-for-value payment models, but he cautioned that we have not reached the tipping point in this transformation yet. He sees the digitization of healthcare as a major trend and predicts growth in the number of players in the industry. He is cautiously optimistic about the direction of the industry because he not only sees companies that are legitimately attempting to reduce costs and improve quality, but also companies that are more concerned about consolidating or integrating to gain leverage at the bargaining table. Dr. Emanuel stressed the importance of distinguishing between deals that enhance quality and deals that enhance leverage, the latter being the type that could create a bubble and crisis. He concluded that competition is essential to the future stability of the healthcare industry, but he invited regulators to consider whether past competition models are appropriate for an industry that is undergoing significant structural change.

Provider Network Design, Contracting Practices, and Regulatory Activity

- Paul Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy, University of Southern California
- Kim Holland, Vice President, State Affairs, Blue Cross Blue Shield Association
- James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association
- Lynn Quincy, Director of the Health Value Resource Hub, Consumers Union
- Fiona M. Scott Morton, PhD, Theodore Nierenberg Professor of Economics, Yale University School of Management
- Anna D. Sinaiko, PhD, MPP, Research Scientist, Department of Health Policy and Management, Harvard T.H. Chan School of Public Health

The first panel presented on emerging network designs in the healthcare marketplace. The speakers particularly examined the competitive implications of narrow and tiered networks and the effects that they have on consumers, recognizing that plan design can directly impact the cost of healthcare. Since the passage of the Affordable Care Act (ACA), health plans have increasingly moved to value-based networks such as narrow and tiered networks. The speakers described a marketplace in which costs and margins vary, and they explained how this incentivizes health plans to identify certain providers that can provide all services at reasonable cost, while recognizing that patients appreciate choice. The speakers noted that HMOs and PPOs are the precursors to value-based network designs. A narrow network, similar to an HMO, has a limited set of providers that deliver healthcare to consumers; they typically are composed of providers offering the lowest costs. Tiered networks, similar to PPOs, are broader network plans that are a response to the problems with more restrictive networks. Tiered networks afford broad networks while identifying providers that offer the greatest value, and they use differential cost sharing to steer patients to preferred providers.

The speakers demonstrated the merits of narrow and tiered networks in terms of cost containment, but they qualified that it likely is too early to determine their overall effectiveness. They asserted that they have general appeal because most consumers will trade broad choice for lower costs. Moreover, they underscored public exchanges as the ideal marketplace for these kinds of networks because a large number of the individuals buying insurance on exchanges are primarily concerned about affordability of healthcare, but they nonetheless touched on employers' increasing awareness of them. The speakers believe that narrow and tiered networks have not reduced consumer choice as much as was originally anticipated, and they were not fearful of quality being sacrificed. They reasoned that the networks accommodate appeals and that there is a general expectation that most hospitals and physicians have relatively high standards of quality regardless of their inclusion in a lower cost network.

The speakers' reservations were mostly based on consumers' current inability to obtain the information that is necessary to make informed decisions about these networks. They were not sure that consumers even knew that they might be in one of these networks. The speakers advocated the introduction of rules to make information more accessible to consumers. To that end, they particularly proposed the creation of summary measures of relative network strength to ensure that consumers are able to effectively weigh plan options, and they said that it is imperative that plan rubrics for the assembling of networks are transparent.

Early Observations Regarding Health Insurance Exchanges

- Cynthia Cox, MPH, Senior Policy Analyst, Program for the Study of Health Reform and Private Insurance, Kaiser Family Foundation
- Daniel T. Durham, Executive Vice President for Strategic Initiatives, America's Health Insurance Plans
- Keith M. Marzilli Ericson, PhD, Assistant Professor of Markets, Public Policy, and Law, Boston University School of Management
- Pinar Karaca-Mandic, PhD, Associate Professor, Health Policy and Management, University of Minnesota School of Public Health
- Kevin Lewis, MPP, CEO, Maine Community Health Options
- Richard M. Scheffler, PhD, Distinguished Professor of Health Economics and Public Policy, School of Public Health, University of California, Berkeley

One goal of the ACA is to create public exchanges that stimulate competition among insurers for individual consumers of healthcare. These exchanges encourage participation in a market that had been neglected in the past, leading to higher costs for individuals or, in many cases, no coverage at all. This panel examined the success of their implementation and offered insights into what the future has in store. The speakers generally were optimistic about the current state of the exchanges and the prospects for enhancement. There has been rapid growth in participation, but they emphasized that more data would be needed to adequately assess competitive effects. They underscored that the success of the exchanges hinges on competition among providers in all of the markets and, to this end, they advocate robust scrutiny on the part of the FTC and DOJ to ensure that there is not undue concentration.

The speakers noted that most individuals purchased the lowest cost plan in 2014, suggesting that insurers will need to especially focus on price to gain market share. They said that consumers have been engaged and have been focusing on value in terms of affordability, quality, and choice. There was discussion about the kinds of plans that are being offered. The speakers corroborated the last panel's presentation on the growing presence of health plans based on narrow physician networks. According to the statistics, narrow network plans have premiums that are 5% to 20% lower than broader network plans. Nonetheless, there was concern among the speakers about the ability of insurers to sustain affordable care in an environment where prescription drug costs have spiked; though the ACA affords consumers protection with regard to out-of-pocket obligations on prescription drugs, they are not insulated from premium increases. Echoing the last panel, the speakers asserted that attention needs to be paid to making information about the plans more accessible to consumers.

There was an illuminating case study of California's experience with the rollout of its exchange. It is distinct in its operation because it is based on the state actively participating in the selection of health plans that meet certain criteria. The speaker noted that California has

had high enrollment in its public exchanges relative to the rest of the country and that the rate of premium growth has materially declined. It, however, is facing lawsuits based on the inadequacy of narrow network plans being offered on the exchanges. The speaker's study showed a positive relationship between concentration in the provider market and premium rates. He believes that this is a significant observation that the federal agencies should continue to investigate.

Wednesday, February 25, 2015

Opening Remarks

- William J. Baer, Assistant Attorney General, DOJ, Antitrust Division

Kicking off day two of the workshop, Assistant Attorney General Baer stressed the importance of "taking a step back on occasion" to evaluate implications for policy, and he said that the workshop was integral to accomplishing that objective. He is encouraged by "some new promising developments" in healthcare. He particularly noted the rise of narrow and tiered networks as a stimulus to competition and a benefit to consumers. He sees innovation in the industry that is contributing to lower costs and higher quality, particularly ACOs.

Mr. Baer appreciated the need for the industry to evolve, but he declared that the agencies will vigorously police the marketplace to ensure that reform does not engender competitive harm. He added that they are committed to challenging anticompetitive mergers, and he cited the St. Luke's case for effect. He remarked on the challenge of distinguishing between procompetitive and anticompetitive hospital-physician mergers. When anticompetitive conduct is successfully challenged, he believes that consumers are entitled to the most effective relief. To that end, he prefers structural remedies because there is inherent uncertainty about the execution of behavioral remedies. He made assurances that the agencies will work on the front-end with businesses to convey fact-specific guidance to the extent that they can.

Early Observations Regarding Accountable Care Organizations

- Alison Fleury, Senior Vice President of Business Development, Sharp HealthCare
- Kristen Miranda, Vice President, Strategic Partnerships and Innovation, Blue Shield California
- David B. Muhlestein, PhD, JD, Senior Director of Research and Development, Leavitt Partners, LLC
- Hoangmai Pham, Director of Seamless Care Models Group, Center for Medicare and Medicaid Innovation
- Terri L. Postma, MD, Medical Officer and Advisor, Center for Medicare at the Centers for Medicare & Medicaid Services
- Simeon A. Schwartz, MD, Founding President and CEO, WESTMED Medical Group
- Chapin White, PhD, Senior Policy Researcher, RAND Corporation

This panel examined the success of ACOs in effecting more efficient and innovative care, and it considered their competitive implications. On the heels of the ACA, the FTC and DOJ issued a joint policy statement about ACOs because of its prominence in the law. ACOs have a basic adherence to a value-based payment mechanism. The speakers confirmed that participation in them is growing rapidly, and they were encouraged by noticeable improvement in quality and cost. Nevertheless, they qualified their confidence in ACOs because they are still early in their development, it takes tremendous resources and infrastructure to effectively operate them, and there is wide variety in the way they are structured.

The speakers outlined two megatrends that ACOs have triggered: 1) a substantial slowdown in medical spending growth and 2) health plans paying progressively higher prices to hospitals. To be sure, these are divergent trends, and they parallel concerns expressed by other panelists about the perverse incentives of some providers to bolster their bargaining power by combining with other providers. Overall, they were optimistic about ACOs propelling us from the traditional pay-for-service model to one based on performance, but they said that there is limited concrete, empirical evidence to help us discern the true intent of these alliances.

Alternatives to Traditional Fee-For-Service Payment Models

- Michael E. Chernew, PhD, Leaonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School
- Suzanne Delbanco, PhD, MPH, Executive Director, Catalyst for Payment Reform
- R. Adams Dudley, MD, MBA, Director, Center for Healthcare Value, Phillip R. Lee Institute for Health Policy Studies, University of California, San Francisco
- Mark W. Friedberg, MD, MPP, Senior Natural Scientist, RAND Corporation
- Bruce E. Landon, MD, MBA, MSc, Professor of Health Care Policy and Medicine, Harvard Medical School
- Lisa McDonnel, Senior Vice President, Network Strategy and Innovation, United Healthcare Networks
- Dana Gelb Safran, ScD, Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts

Building on the last discussion about ACOs, this panel surveyed the many options that are available in the market for decreasing costs and increasing quality. The speakers prefaced their presentation by proclaiming that we still are not certain of which alternative model will most effectively move us away from fee-for-service. They agreed that the fee-for-service model was unsustainable, but they cautioned that today's alternatives may lead to consumers not paying for services that they truly need. To be sure, fee-for-performance models have not produced the changes that are necessary for wholesale reform but rather have had smaller, incremental effects. They were not able to answer the question of whether one payment model – fee-for-service, fee-for-performance or capitation – is going to be better than another, and they said that they are seeing a mixture of all three in many instances.

The speakers particularly noted the parallel between ACOs and patient-centered medical homes (PCMHs). Like ACOs, PCMHs, at least in theory, can lead to higher quality and lower costs. PCMHs are focused on primary care, and the speakers asserted that ACOs will only be successful to the extent that they incorporate strong primary care practices. In sum, both ACOs and PCMHs are organizations founded on accountable care, their models are converging and they will need to integrate.

The speakers promoted the adoption of standards that can be used by consumers to hold providers more accountable. They further advocated transparency, so consumers could navigate payment models that are exceedingly complex. Nonetheless, they asserted that transparency is secondary to the achievement of better alignment between consumers and the healthcare system, which is being advanced by these new payment models. They stressed that any provider, regardless of size and scale, can align with other providers to ensure that they are able to bear the risks associated with pay-for-performance models, as long as the requisite tools are made available to them.

Trends in Provider Consolidation

- Lawton Robert Burns, PhD, MBA, Director, Wharton Center for Health Management and Economics, University of Pennsylvania
- Leemore Dafny, PhD, Director of Health Enterprise Management, Kellogg School of Management, Northwestern University
- Martin Gaynor, PhD, E.J. Barone Professor of Economics and Health Policy, Carnegie Mellon University
- Kenneth Kizer, MD, MPH, Director, Institute for Population Health Improvement, University of California Davis Health System
- James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association
- Joe Miller, General Counsel, America's Health Insurance Plans

This panel presented its findings on the effects of provider consolidation on the cost and quality of healthcare. They particularly shared insights into mergers between hospitals and physician groups, the kind of transaction challenged in St. Luke's. The consensus is that there is little evidence suggesting that this kind of integration has been improving cost and quality. On that note, the speakers claimed that an integrated delivery system is not necessarily synonymous with integrated patient care. They further questioned whether there are significant efficiencies to be gained from this kind of integration that otherwise could not be attained via contracting. They warned that integration can reduce competition in the market for physician services and thus increase the prices paid by consumers.

There also was considerable discussion about cross-market consolidation. Hospitals have been consolidating significantly over the last two decades, and today, there are few independent hospitals. Many of those combinations span different geographic and product markets. The speaker's study showed that this kind of merger tends to lead to higher hospital prices. She also said that the evidence was unclear about the efficiencies that derive from this kind of deal. Considering this evidence, she admonished the agencies to pay closer attention to potential anticompetitive effects in this context.

The speakers briefly touched on consolidation between insurers and providers. They see advantages and disadvantages to this kind of integration. On the one hand, it could increase competition and value, but on the other hand, it could create inefficiencies. The speakers remarked that both insurers and providers contribute something to the quality of healthcare and that we need to determine the best way to align their functionalities. In response to a question, the speakers disagreed with the notion that enforcement agencies should not be concerned about this kind of integration because fee-for-performance has caused insurers' and providers' interests to be closely aligned. They affirmed that competition is going to be vital and said that a different approach would require the agencies to substitute regulation for competition, which would be contrary to our country's free market system.

Finally, the speakers vehemently disputed the view that the ACA is forcing providers to consolidate. They explained that the ACA is agnostic about how to accomplish cost and quality improvement and that the antitrust laws unequivocally continue to apply to healthcare in the same manner as they apply to other industries. They said that many people misinterpret the ACA to mean that the government is implicitly encouraging consolidation. They nevertheless believe that providers are consolidating because they are uncertain about government policy.

Summation Roundtable: Antitrust Perspectives on Evolving Provider and Payment Models

- Mark J. Botti, JD, Partner, Squire Patton Boggs LLP
- Martin Gaynor, PhD, E.J. Barone Professor of Economics and Health Policy, Carnegie Mellon University
- Thomas L. Greaney, JD, Chester A. Myers Professor of Kaw and Co-Director of the Center for Health Law Studies, Saint Louis University School of Law
- Dionne Lomax, JD, Partner, Mintz Levin Cohn Ferris Glovsky and Popeo, PC
- Mark B. McClellan, MD, PhD, Senior Fellow in Economic Studies & Director of The Health Care Innovation and Value Initiative, The Brookings Institution
- Monica Noether, PhD, MBA, Vice President, Charles River Associates

Rounding out the workshop, this panel concentrated on the implications of the foregoing developments for antitrust policy. The speakers first discussed ACOs, seeing them as a natural starting point. They agreed with the prior panels on the difficulty of discerning the competitive effects of these organizations, given that they are in the early stages of development. Notwithstanding that obstacle, they do not believe that ACOs are raising antitrust concerns because the vast majority of them comprise smaller providers and it appears that they are capturing benefits in many ways other than consolidation. The speakers also thought that the agencies need to pay closer attention to cross-market mergers because, in many ways, they can raise more concerns than other kinds of mergers.

There was a relatively charged debate about St. Luke's implications for efficiency arguments. The speakers generally thought that the decision places an undue burden on defendants. They argued that it could have a chilling effect on procompetitive mergers because providers will perceive the antitrust barriers to be insurmountable. They believe that the decision indicates that evidence of decreased costs and increased quality will not carry the day. Perhaps most important, they disputed other speakers' assertion that the form of integration is relatively insignificant. They declared that there certainly are some objectives that you cannot accomplish without a merger and, using Kaiser as an example, they contended that

there probably will need to be mergers to achieve some incentive alignment. At least one speaker contested merger-specific efficiencies and asserted that we should start from the presumption that mergers in healthcare are not creating efficiencies. One speaker took exception to that assertion, stating that the efficiencies argument needs to be accorded some measure of respect in the agencies' review because it otherwise would undermine the aims of the ACA.

The speakers were optimistic about implementation of exchanges. They believe that they have been designed well to accomplish their purpose. They advised the regulators to not create barriers to entry and let them become worse than what they were intended to be. They agreed with California's active participation in the market because it has proven to be a stimulator of competition. They reiterated prior speakers' concerns regarding the general lack of information about narrow and tiered networks that consumers can use to make informed decisions about healthcare on the exchanges. They also are apprehensive of the growing popularity of high deductible plans because their ill-advised use may undermine the viability of the market. Thus, they contend that an appropriate amount of consumer protection will be indispensable to the future health and stability of exchanges. The speakers agreed that the exchanges are the ideal marketplace for narrow networks because they are more suitable for individuals than employers that are contracting with health plans for an entire group's healthcare needs.

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