Testimony of David Balto, Senior Fellow
Center for American Progress Action Fund

Before the House Judiciary Committee,
Subcommittee on Courts and Competition Policy
on H.R. 3596, the
"Health Insurance Industry Antitrust Enforcement Act of 2009"

October 8, 2009

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Chairman Johnson, Ranking Member Coble and other members of the Subcommittee, I appreciate the opportunity to come before you today and testify about health insurance competition and consumer protection enforcement. As a former antitrust enforcement official I strongly believe the mission of the Federal Trade Commission and Antitrust Division of the Department of Justice is vital to protecting consumers and competition. However in the past administration the priorities of those enforcement agencies were not effectively aligned with the critical priorities in the health care market, with the result that there is substantial anticompetitive and fraudulent activity in the health insurance market that raises prices and costs for consumers and the American taxpayer.

Today's hearing is on "H.R. 3596, the 'Health Insurance Industry Antitrust Enforcement Act of 2009'" which will amend the McCarran-Ferguson Act to provide that certain anticompetitive conduct by health insurers and medical malpractice insurers is not immune under the act. That is a good first step to reforming health insurance markets. But the ability for health care reform to succeed depends upon all aspects of health care markets to function effectively, and by any measure, the health insurance market is broken—with supracompetitive profits, escalating numbers of uninsured, an epidemic of deceptive and fraudulent conduct, and rapidly escalating costs. Today, 47 million Americans are uninsured, while those who are insured have seen their premiums rise over 120 percent in the past decade.[1] Meanwhile, 10 of the largest health insurers saw their profits balloon from $2.4 billion in 2000 to $13 billion in 2007.[2] There have been dozens of state enforcement actions securing potentially over $1 billion in fines and penalties. As I describe in my testimony, for health care reform to work we need greater congressional oversight and investigation of health insurers, comprehensive regulatory reform, and a realignment of priorities at the DOJ and FTC.

Former Justice Brandeis said that sunlight is the best disinfectant and Congress deserves substantial credit for the attention it has given to the competitive and consumer protection problems in health insurance markets. Members on either side of the aisle may disagree about the scope of health care reform, but I would hope there is little dispute that recent congressional hearings have uncovered a disturbing pattern of egregious, deceptive, fraudulent and anticompetitive conduct in health insurance markets. That conduct must be stopped.

Last month, the Domestic Policy Subcommittee of the House Oversight and Government Reform Committee held an important hearing titled "Between You and Your Doctor: The Private Health Insurance Bureaucracy." In this hearing, consumers came forward and courageously told their stories about the egregious practices health insurers regularly engage in to avoid paying for health care and to ensure excessively high profits.

- Mark Gendernalik of West Hills, California, described how his health insurer created obstacles to his efforts to get his three-month-old daughter proper treatment for infantile spasms: "Consumers should not have to endure this kind of life-and-health threatening hassle. I hope Congress will find better ways to ensure that insurers deliver on the care they promise. The stress of constantly having to hold the HMO and their agents to their agreed upon obligations has relegated me to the role of my daughter's care manager, and all too often robbed me of my role as Sidney's loving daddy."[3]

- Errin C. Ackley of Red Lodge, Montana described her battle against Blue Cross Blue Shield of Montana to secure care for her father who was dying of Chronic Lymphocytic Leukemia. BCBSMT claimed that a transplant was still "investigational," and it took four months of letter writing, phone calls, and presentations of scientific data on the efficacy of the procedure, and legal work to convince the insurer to cover the procedure. After four months' delay, her father received the transplant but passed away just a few months later. Erinn testified, "Would there have been a different end to my dad's story if he had been given approval for the first transplant request in April 2006? …We don't know. What we do know is that his chance for survival most assuredly did not increase because . . . Blue Cross Blue Shield of Montana built the bureaucratic roadblocks that changed the course of my father's treatment and made him wait four months for his potentially life-saving bone marrow transplant."[4]

- Wendell Potter, a former insurance executive, revealed the most basic motivation for these practices, one that will not necessarily disappear with the regulations of health care reform. Potter testified, "To win the favor of powerful [investment] analysts, for-profit insurers must prove that… the portion of the premium going to medical costs is falling… To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick."[5] This practice, known as "purging," allows insurers to avoid paying for health care for those who need it most, and instead collect premiums with the explicit intention of avoiding paying for care.

Health insurance companies mounted every obstacle possible to Mark's daughter's treatment and to Erinn's father's bone marrow transplant. As Wendell Potter documented their incentives are to satisfy Wall Street, to deny care, and to maximize profits. Even Judge Richard Posner has observed that the "incentive [of some insurers] is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."

I know from my experience as a government antitrust enforcer that there are three elements for a market to effectively function: transparency, choice and a lack of conflicts of interest. All of these elements are lacking in health insurance markets. **Few markets are as concentrated, opaque and complex, and subject to rampant anticompetitive and deceptive conduct**. A recent report by the Congressional Research Service states it plainly: **"**The health insurance market has many features that can hinder markets, lead to concentrated markets, and produce inefficient outcomes."[6] As the health care debate progresses, many advocate for limited reform of the health insurance system. Their belief is that it is a fundamentally sound market and with a

little dose of additional regulatory oversight, all the ills of the market will be cured. They could not be more mistaken.

Here are the essential points of my testimony:

- From both a competition and consumer protection perspective health insurance markets are severely dysfunctional. Few markets are as concentrated, opaque, and a fertile ground for deceptive and anticompetitive conduct. Relying on these markets as currently structured in health care reform would be a serious error and weaken the chance for any successful reform.
- These competitive and consumer protection problems are exacerbated by regulatory neglect by federal antitrust and consumer protection enforcers (the Justice Department and Federal Trade Commission). During the Bush administration there were no actions against anticompetitive or deceptive conduct by health insurers. Hundreds of mergers were approved with only the minor restructuring of two mergers.
- The most effective means of addressing the broken market structure is the creation of a public plan, as envisioned in the House legislation.
- In any case, the record of regulatory neglect must be reversed. There must be significant regulatory reform to begin to attempt to grapple with the broken health insurance markets.

My recommendations include:

- Congress should enact H.R. 3596. But it should go further. It should amend the statute to eliminate potential obstacles to FTC enforcement against anticompetitive and deceptive conduct.
- Congress should increase its vigilance of health insurance markets and increase its own scrutiny of anticompetitive and deceptive practices.
- The Obama administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious and deceptive conduct by insurers.
- The FTC should significantly increase health insurance consumer protection enforcement and create a separate division for health insurance consumer protection enforcement.
- The DOJ and FTC should reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should use its full powers under Section 5 of the FTC Act to prosecute anticompetitive conduct that may not violate the Sherman or Clayton Act.
- The FTC and DOJ should establish much stronger standards for health insurance merger enforcement under their Merger Guidelines. The FTC should conduct a retrospective study of health insurer mergers to identify those which have harmed consumers.
- Congress should require transparency of all health care intermediaries, including health insurers, Pharmacy Benefit Managers, or PBMs, and Group Purchasing Organizations or GPOs, as a part of health care reform.

I. Rampant competitive and consumer protection problems in health insurance

Let me begin with my earlier observation – the importance of choice and transparency to assure a competitive marketplace. Why are choice and transparency important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these two elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice. As the Health Care for America Now report observed "Without competition among insurers, insurers have no reason to drive down costs, and without additional choices in the marketplace, consumers have no choice but to pay inflated prices."[7]

As I describe below there has been no meaningful federal antitrust or consumer protection enforcement against health insurers. None. The result of the lack of health insurance enforcement is profound. The number of uninsured has skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn't really protect them. In the past six years alone, health insurance premiums have increased by more than 87 percent, rising four times faster than the average American's wages. Health care costs are a substantial cause of three of five personal bankruptcies. At the same time from 2000 to 2007, the 10 largest publicly-traded health insurance companies increased their annual profits 428 percent, from $2.4 billion to $12.9 billion.

A. A tsunami of mergers has created a competitively unhealthy market structure

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: in a recent report by Health Care for America Now, in 39 states two firms control at least 50 percent of the market and in nine states a single firm that controls at least 75 percent of the market.[8] A 2007 AMA study found almost 95 percent of all markets are highly concentrated.[9] Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but just follow the lead of the price increases of the larger firms.

During the past administration there was massive consolidation of health insurance markets. As then Presidential Candidate Barack Obama observed,

There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20 percent since 2000. These changes were supposed to make the industry more efficient, but instead premiums have skyrocketed, increasing over 87 percent over the past six years.[10]

There is little evidence that this wave of consolidation led to significant efficiencies, or lower costs, or other benefits. In fact, the fact that insurance premiums continued to rapidly increase

suggests that any efficiencies were simply pocketed by the companies, rather than resulting in lower premiums or other consumer benefits.

As Vermont Senator Patrick Leahy observed in hearings before the Senate Judiciary Committee in 2006 on health insurance consolidation:

> A concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[11]

Competition matters: in a recent study Professor Leemore Dafny of the Northwestern University's Kellogg School of Management documents the high cost of the recent increases in concentration. She estimates that the rise in the concentration of health insurers from 1998 to 2006 led to an overall increase in premiums of 2.1 percent, or $17 billion in extra profits, in essence over $2 billion a year. She also concludes that, in a concentrated market, insurers may enjoy monopsonistic power over health care providers, and as a result, physicians in that area earn less than they otherwise would.[12] A more general study noted that insurance premiums are 12 percent lower in those markets in which there is comparatively a lower level of concentration than in more concentrated markets.[13] These facts together confirm that antitrust concerns are certainly present in the health insurance industry, and the strength of federal enforcement and oversight should reflect this.

One cannot expect competition to break out in any of these markets in spite of the significant profit margins of the incumbent insurers. Recent history has demonstrated that it is practically impossible for new firms to enter metropolitan markets dominated by large insurers. There are numerous barriers to entry including the reputation and brand name of the incumbent insurers—especially when it is a Blue Cross plan—developing sufficient business to permit the spreading of risk, most favored nations provisions and all products clauses that tie up providers and the cost of developing a health care provider network. The failure of large financially successful firms such as United to enter major metropolitan markets speaks volumes about the substantial entry barriers.

In evaluating the competitive health of a market, antitrust enforcers typically look at three factors: concentration, entry barriers, and profits. Health insurance markets, by any measure, are highly concentrated. Substantial barriers to entry assure that concentration will not dissipate based on natural market forces. The lack of competition results in supracompetitive profits. Health insurance is clearly a structural broken market.

B. Anticompetitive practices go unchallenged

Similar to the history of regulatory neglect in mergers, the Bush administration did not bring a single case challenging anticompetitive conduct by insurance companies. Certainly there are various types of conduct by dominant insurers that deserve very careful scrutiny because they reinforce dominance and prevent rivals from entering and expanding.

Practices such as most favored nations provisions, all products clauses, and silent networks, which limit the ability of providers to enter into arrangements with rival insurers, increase the power of the insurer at the expense of the health care provider and limit the ability of rival insurers to enter and expand in the market. For example, a most favored nations' provision prevents providers from entering into more attractive arrangements with new entrants into the insurance market. Other provisions may prevent physicians from making consumers aware of more attractive insurance products which may provide better coverage. Some of these practices were challenged in the Clinton administration, but the Bush administration, which took a mistakenly permissive view to conduct by dominant firms throughout the economy did not mount a single challenge.

Moreover, dominant insurers rarely invade each other's territories. This is disturbing since these firms certainly have the resources, incentives, and ability to enter new markets. The fact they choose not to raises serious concerns of market allocations. Take, for example, the fact that Blue Cross and Blue Shield plans hide behind a complicated system of licensed-based territorial allocations to claim that they don't compete with one another, even when there are multiple plans in the same state. This territorial allocation claim may have been what prompted the Bush administration to take a pass on challenging the proposed Highmark-Independence Blue Cross merger in Pennsylvania. These allocations eliminate important sources of potential competition. The FTC should investigate and challenge these practices. It seems doubtful that a court looking at the Pennsylvania situation would have viewed such territorial allocations as procompetitive.

C. Deceptive, fraudulent, and egregious practices are unchecked

The hearings held by the Senate Commerce Committee and the Domestic Policy Subcommittee of the House Oversight and Government Affairs Committees documented that insurance companies engage in a wide variety of fraudulent, deceptive and egregious practices. As Wendell Potter testified before the Senate Commerce Committee, "Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand—or even to obtain—information we need."[14]

Moreover, as the Domestic Policy Subcommittee heard health insurers regularly find, create, and exploit loopholes to deny consumers the coverage they paid for and deserve. The harm to consumers in suffering is profound.

Consider, for example, the Ingenix matter—the recent scandal over abuse of an industry price-setting database that health insurers used to artificially depress reimbursements to consumers. For several years, United used its wholly owned subsidiary, Ingenix Corp., to calculate reimbursement rates for out-of-network coverage. These rates were artificially deflated, allowing United to lowball payments to customers. Consumers were systematically underpaid by millions of dollars. The New York State Attorney General's Office sued United over Ingenix and has secured over $94.6 million so far, and a class action suit by the American Medical Association settled for $400 million.[15] Numerous private suits continue.[16] As New York Attorney General Andrew Cuomo stated in testimony before the Senate Commerce Committee in March, Ingenix was "a huge scam that affected hundreds of millions of Americans [who were] ripped off by their insurance companies."[17]

As described below, there were no federal enforcement actions against deceptive or fraudulent activity by health insurers. This lack of federal oversight and the insurers' successful battle against regulation gave insurers great latitude to invent deceptive and fraudulent schemes to harm consumers. Insurers engage in a veritable laundry list of deceptive and abusive conduct such as egregious preapproval provisions, deception about scope of coverage, unjustifiably denying or reducing payments to patients and physicians, and other coercive and deceptive conduct.

In addition to the aforementioned Ingenix case, insurers have been found liable or settled charges for a wide variety of fraudulent and deceptive conduct including: utilizing falsified data to calculate reimbursements, refusing to pay for visits to providers erroneously listed as in-network; wrongfully denying claims for sick patients; failing to pay reimbursements in a timely manner; overcharging customers for premiums; refusing to cover emergency treatment; failing to provide notice of rate increases; ignoring customer complaints; and various other similar methods of denying needed care while maximizing profit. There are countless complaints by hospitals and physicians that preapproval provisions prevent them from providing adequate and safe care. In testimony before the Senate Commerce Committee, Consumers' Union characterized the insurance payer system as plagued by "a swamp of financial shenanigans" – including a lack of transparency, conflicts of interest, and deceptive practices – and called on regulators and enforcers to step up actions to "prevent egregious consumer ripoffs."[18]

To combat this conduct, state attorneys generals, insurance commissioners, and private parties have brought over 50 cases securing potentially more than $1 billion in damages and fines since 2000. Although these state actions are laudable, state enforcement is episodic and can only repair a problem involving a single company in a single state. Trying to fix these endemic problems with lawsuits is like treating cancer with a bushel of Band-Aids.

These numerous enforcement actions do not suggest however that state enforcement is an adequate substitute for federal enforcement. Indeed the contrary is true. The level of enforcement resources that insurance commissioners possess varies significantly from state to state. Most states have relatively limited resources at best to police the insurance industry.[19] In addition, state laws serve at best as a patchwork quilt to address consumer protection issues. Further, self-insured health care plans, which account for more than 40 percent of the private health insurance market, are not subject to state regulation. Thus state regulation is far from an adequate substitute for federal regulation of health insurance.

Moreover, the lack of transparency is a chronic problem. In a June letter to several key congressional leaders, Consumer Watchdog called for Congress to enact a "Patient Bill of Rights" and detailed a number of ways in which health insurers deliberately mislead and underpay patients, including: issuing excessive fine print that allows them to deny coverage for common procedures, failing to define "medical necessity" and "experimental treatment," creating junk policies that are "not worth the paper they're printed on," and manipulating risk to refuse coverage for ailments while charging higher rates.[20] Health insurers allege that they have largely abandoned the practice of forcing "gag clauses" on physicians that prohibit them from discussing insurance alternatives or reimbursement procedures; however, many physicians report

having their hands similarly tied by "business clauses" that require many of the same concessions.[21] Consumers cannot access certain information about their benefits and insurers adjudicate claims based on inscrutable and even fraudulent formulas.

As I described in recent testimony before the Senate Commerce Committee, the lack of enforcement was not due to a lack of resources but rather a serious misjudgment about where to devote enforcement resources.[22] Rather than focusing on insurers almost all the enforcement actions were brought against physicians. The missions of the enforcement agencies should be focused on those areas which have the greatest impact on the economy and consumers. The anticompetitive and deceptive conduct by health insurers has a far more profound impact than any anticompetitive conduct by physicians.

D. The harm to small businesses and individual consumers

Overall, the total lack of antitrust enforcement results in rapidly increasing premiums, increasing profits, greater numbers of uninsured and noncompetitive market structures in all but a handful of markets.

Small businesses are particularly vulnerable to the exercise of market power by insurers because of their limited options. The recent health insurance crisis has hit small businesses particularly hard, and as premiums escalate it is increasingly difficult for small businesses to offer coverage. The lack of competition makes it impossible for the majority of small business owners to offer their employees insurance. To do so, small business owners must navigate complex plan structures that do not offer the cost-saving benefit of large risk pools that large employers enjoy. A survey of small business owners showed a clear correlation between the size of a business and its premiums—the smaller the businesses, the higher its premiums.[23] It is often too expensive for many small businesses to insure their employees, who are then left to navigate the individual health insurance market—which is even more daunting—or simply go uninsured. As a result of insurers' unrealistically high premiums, only 38 percent of small businesses offer coverage to the employees, down from 61 percent in 1993. Because small businesses employ about half of the country's private sector workers, this means that health insurers are discriminating against a huge share of the population.[24]

Wendell Potter, a former health insurance executive, has explained why health insurers treat small businesses so poorly. In testimony before the House Oversight committee, Potter writes that health insurers, in order to cut costs and ensure high profits, "dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance companies to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether—leaving workers uninsured."[25] The few dominant insurers in any given market continue this practice year after year without challenge or competition from insurers who are willing to offer lower premiums to these groups.

II. One cause: A record of regulatory failure

Why aren't health insurance markets working for American families? The answer, at least initially is regulatory failure. Health insurers are governed by a hodge-podge of local, state and federal regulations. Moreover, these companies have fought tooth and nail over the last decade against any regulators' attempts to institute even basic consumer protection measures—including, crucially, killing the original patients' bill of rights legislation in 2001.

Instead of a vibrant, competitive marketplace, the lack of a sound regulatory and enforcement regime has allowed the development of a highly concentrated system in which deceptive and abusive practices flourish with inadequate checks from rivalry or regulation. With insufficient choice and severely limited transparency in the market, consumers suffer from egregious and anticompetitive practices.

As documented above, there have been no enforcement actions against anticompetitive conduct by health insurers. Not a single action. Almost all of the health care enforcement resources of the FTC and the DOJ have been spent going after physicians – over 30 cases in the Bush administration.[26]

The Bush administration reviewed numerous mergers, but approved all of them, requiring some modest restructuring in two mergers. In one case—Highmark's proposed acquisition of Independence Blue Cross—it chose not even to engage in an extensive investigation, despite the fact that, if the two insurers merged, the new insurer would have held over 70 percent of the Pennsylvania market and formed the sixth-largest insurer in the country. Allowing such a large firm to dominate a single market would make the barriers to entry nearly insurmountable, and consumers would be faced with few options.[27] Ultimately the Pennsylvania Insurance Commissioner reached the opposite decision and found such severe competitive problems that the parties were forced to abandon the acquisition.[28] It is not unusual for the states to step in where the federal enforcers fail to effectively challenge these mergers. There have been several cases where state insurance commissioners have secured remedies even where the federal enforcers have failed to challenge mergers.

The federal consumer protection enforcement record is as bleak as the competition record. The FTC has not brought a single case against deceptive or fraudulent conduct by health insurers. All of the FTC's health care consumer protection enforcement actions were brought against advertising of sham products, such as miracle diet pills, that capitalize on consumers' willingness to be deceived.

This lack of federal oversight and the insurers' successful battle against regulation gave insurers great latitude to invent deceptive and fraudulent schemes to harm consumers. Insurers engage in a veritable laundry list of deceptive and abusive conduct such as egregious preapproval provisions, deception about scope of coverage, unjustifiably denying or reducing payments to patients and physicians, and other coercive and deceptive conduct.

The federal enforcers have not restricted the drive for consolidation nor limited the extent to which insurers could abuse the resulting market power. The result was the tsunami of health insurer consolidation and the accompanying wave of abusive business practices that have stuck small businesses and consumers with unreasonably high premiums and inadequate coverage.

Indeed, a report by the Medicare Payment Advisory Commission, an expert panel appointed by Congress, found that insurers "have been able to pass costs on to the purchasers of insurance and maintain their profit margins."[29] Moreover, as health insurers have used their market clout to reduce reimbursement for smaller health care providers, those providers – disproportionately concentrated in rural or urban underserved areas – have been forced into offering assembly-line health care.

Why is there an imbalance in enforcement and a lax position on the conduct of health insurers? Perhaps that is because the agencies treat the insurer as if it is the consumer. If they do, that is a mistake. Insurers do attempt to control costs for employers and other purchasers of health plans. But their primary goal is to fulfill the expectations of Wall Street, and the record of egregious, deceptive, and anticonsumer conduct speaks volumes about whether they act in the interest of consumers.

III. A public plan is essential to reform the market.

The lack of competition and record of egregious deceptive practices demonstrates the need for a public plan. A public plan offers the promise of being able to enter these markets currently controlled by monopoly or oligopoly for-profit insurers. The entry of the public plan, based on a nonprofit model and with greater efficiency and lower costs, will disrupt the cozy life of these dominant insurers. This will force down premiums in a fashion that antitrust enforcement will never achieve.

A public plan will be the type of competitive "maverick" in the market that offers the potential to restore competition. Unlike the current for-profit insurers, a public plan does not have the need or incentive to raise and protect its profit margins. Nor does it have any incentive to flout or manipulate regulations. Its concerns are not profit, but the public health.

Moreover, a public plan will set a model of consumer protection compliance, not abuse. With a public plan, the rival insurers will not be able to compete down the level of consumer protections or engage in collusive practices to harm consumers, such as the Ingenix example. Rather, the public plan will serve as a model of consumer protection compliance. The marketplace will then compel rival insurers to meet those standards or face the potential loss of consumers. As President Obama put it, the check of a public plan would keep health insurers "honest."

Overall, competition from a public plan would force insurers to respond to market forces, reducing prices and improving consumer protections. Those who survive the competitive battle will be those with reasonable premiums and superior customer service. As the Urban Institute puts it, "Incentives for them to innovate in the areas of cost containment and service delivery will be enhanced by the presence of a well-run and effective public plan."[30]

The misplaced criticism of the public plan

Health insurers decry the emergence of the public plan. That is not surprising. No competitor likes competition, especially when they are able to exercise market power, avoid regulation, and reap supracompetitive profits. To counter competition, the opponents suggest that competition

with the public plan will ultimately lead to the demise of the private health insurance market. Their arguments are inconsistent with the economic realities of these markets.

The public plan opponents argue that Americans normally don't respond to lack of competition by creating a government-run entity, such as a grocery store or a gas station. But those aren't oligopoly markets with high entry barriers in which prices and profits have escalated rapidly. Besides, health care is a different kind of marketplace. As a society we have an obligation to make sure people have access to affordable health care. Moreover, grocery and gas station businesses are essentially transparent, unlike the health insurance business, whose customers do not know what their premium dollars will get them. The primary goal of for-profit insurance companies is to make money for their shareholders. Because they have successfully shielded their coverage rules and policies from public inspection by labeling them trade secrets, they can use egregious practices to deny coverage with inadequate accountability.

The opponents also suggest that the public plan will drive its rivals from the market, perhaps through predatory conduct. This claim is simply inconsistent with the strong position of these powerful dominant health insurers. The major health for-profit health insurers—United, Aetna, Cigna, Wellpoint, Humana, and others—have tremendous financial reserves. In addition, as publicly traded companies they can call on the market for even greater financial support. The nonprofit Blue Cross firms, which dominate dozens of markets, have tremendous financial reserves. Simply, these firms are not about to be driven from the market by the emergence of a public plan.

Insurance companies complain that the proposed public health insurance plan will have unfair advantages and drive them from the market. These claims bear little relation to market realities. These firms are well-funded, sophisticated, and endowed with tremendous financial and human resources. As a former federal antitrust enforcement official, I know that they complain for the reason every competitor complains when a new rival arises – competitors never like competition.

Opponents of a public plan suggest that a plan will become too powerful and will exercise concentrated buying power that will hurt the quality of care. Unlike for-profit firms, a public plan has no incentive to cut corners and prevent providers from giving their patients quality evidence-based care, because its ultimate goal is public health, not private profit. Nor does it have any interest in sideswiping regulations and shortchanging consumers. Free market proponents argue that private health insurers should be lightly regulated to give Americans the best value. We have seen the results of that sort of regulatory neglect in many industries in the past eight years; the harm to all Americans, businesses and the overall economy could not be more profound.

IV. Reform of the McCarran-Ferguson Act is important

In addition to a public plan, heightened antitrust enforcement of health insurers is absolutely necessary to inject competition in the market. H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009," will clarify that the immunity of the McCarran-Ferguson Act will not apply to health insurers or medical malpractice insurers. I think it is relatively clear that the elimination of this immunity will not inhibit any procompetitive conduct of health

insurers or medical malpractice insurers. The Clinton administration endorsed a similar reform of the McCarran-Ferguson Act as part of its healthcare reform initiative. Clarifying the limits of the McCarran-Ferguson Act is important, and Congress should seriously consider repealing the Act altogether.

Congress must take further steps, though, to ensure that the federal government can effectively protect consumers who have been the victim of the anticompetitive and egregious practices I have described so far. Giving the FTC jurisdiction where only state insurance commissioners are now involved would benefit consumers enormously. Currently, when health insurers overcharge or otherwise abuse consumers, their only recourse is to their state's insurance commissioner. Under most state laws, individuals have no private right of action under the insurance rating law or unfair insurance trade practices act. And state insurance commissioners have very limited resources. Congress should amend the McCarran-Ferguson Act to permit the FTC to take action against unfair or deceptive practices in the health insurance industry and provide the strong consumer protection on the federal level that consumers urgently need.

V. The potential for health care reform to promote competition and protect consumers

As a part of health care reform, there is a clear need for regulatory reform. As I have noted before, we depend on a patchwork of state laws, which seem insignificant in comparison to the scope and scale of egregious consumer protection violations and anticompetitive conduct in the health insurance industry. Many states have ineffective laws to address these problems or lack the resources to even enforce their laws. Congress has grappled with this as a part of its health care reform proposals, but there needs to be a more comprehensive approach.

Congress must act to correct the endemic problems in the health insurance market. To start, they should fully utilize their investigatory powers to look into anticompetitive and deceptive conduct by health insurers. This year alone, Congress has conducted many investigations and spent time looking into practices by health care intermediaries that may be harming consumers or needlessly adding to the country's health care spending. Some of their most significant efforts are listed below.

- An investigation into the Ingenix scheme, described above, by the Senate Commerce Committee helped put an end to one of the most widespread consumer abuses in health insurance history;
- Ongoing efforts by the House Energy and Commerce Committee and Oversight and Government Reform Committees to reveal the types of fraudulent and deceptive practices by health insurers that I have described have played a large role in the sense of urgency and duty that has marked health care reform this year; and
- The Federal Employees, Postal Service and District of Columbia Subcommittee of the House Oversight and Government Reform Committee has sparked discussion of the often-ignored PBM industry by investigating their role in the Federal Employees Health Benefit Program.

All of these efforts should be strengthened and reinforced; Congress can play a critical role in exposing harmful practices in the health insurance market – shining the "sunlight" that Justice Brandeis explained is the best disinfectant here.

Below are some of the proposals Congress has put forth in its various health care reform bills which would improve consumer protection and promote competition. What is sorely needed, though, is a federal enforcement mechanism to ensure that these requirements are met by the health insurance companies and to protect the interests of consumers. The House Tri-Committee bill would establish a Health Choices Administration with a commissioner appointed by the President with the authority to enforce the requirements imposed on health insurers by the bill. The Senate Finance bill does not create such an entity, though, and relies largely on state insurance commissioners to enforce the bill's many requirements. Without a strong federal entity that consistently enforces these regulations and has the authority to help consumers, we might not be able to avoid the egregious situations documented in the recent hearings.

- The Senate Finance bill will simplify the process of shopping for health insurance by requiring standardized marketing guidelines, a standard format for presenting insurance options, and a standard enrollment application. This would allow consumers to directly compare the terms and costs of insurance plans and make well-informed purchasing decisions.
- The House Tri-Committee and Senate Finance bills each create an ombudsman to receive consumer complaints and act as a consumer advocate, either on the state or federal level.
- The Senate Finance bill sets aside $30 million for consumer assistance organizations on the state level. These programs would help consumers navigate complex health insurance plans and protect themselves from consumer protection violations.

These proposed regulations reflect efforts from *within* the health care system to promote competition and to protect consumers. These efforts must be matched by the federal antitrust agencies, though, to provide adequate oversight and enforcement.

VI. Recommendations for revitalizing competition and consumer protection enforcement

Ultimately, strong consumer protection and antitrust enforcement on the federal level is essential for health care reform to work. Below are some recommendations for building a solid structure for competition and consumer protection enforcement in health care.

1. **The Obama administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious and deceptive conduct by insurers.** The structure of the health insurance market is broken and the evidence strongly suggests a pervasive pattern of deceptive and egregious practices. Health insurance markets are extremely concentrated, and the complexity of insurance products and opaque nature of their practices make these markets a fertile medium for anticompetitive and deceptive conduct.

2. **Create a vigorous health insurance consumer protection enforcement program.** The FTC's health care consumer protection enforcement currently focuses on marketers of clearly sham and deceptive products. This is unfortunate. In many other areas, such as financial services, the FTC uses a broad range of powers, including studies, workshops, policy hearings, legislative testimony, and industry conferences to better inform marketplace participants of how to properly abide by the law. The FTC should adjust its healthcare consumer protection enforcement to focus on health insurers, and other health care intermediaries such as PBMs. These efforts should focus both on enforcement to prevent egregious and fraudulent practices and to assure that there is a sufficient amount of information and choice so that consumers can make fully informed decisions. Because of the importance of these issues, especially in controlling health care costs, the FTC should establish a new division for health insurance consumer protection.

3. **Reinvigorated enforcement against anticompetitive conduct.** The DOJ and the FTC need to reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should scrutinize anticompetitive conduct and use its powers under Section 5 of the FTC Act. As this Committee knows, Section 5 of the FTC Act can attack practices which are not technical violations of the traditional antitrust laws, the Sherman and Clayton Acts. Thus the FTC can use that power under Section 5 to address practices which may not be technical violations of the federal antitrust laws, but still may be harmful to consumers. As I have testified elsewhere, the FTC should begin to use that power under Section 5 to attack a wide range of anticompetitive and egregious practices by health insurers, PBMs, and GPOs.

4. **Stronger health insurance merger enforcement and a retrospective study on consummated health insurance mergers.** During the Bush administration there was significant consolidation in health insurance markets. If the FTC and/or Justice Department lacks sufficient resources to effectively challenge anticompetitive mergers, they should be given those resources. If the current merger standards do not appropriate to effectively challenge these mergers, those standards should be reevaluated. Simply, the public cannot afford any greater consolidation in health insurance markets.

5. **Conduct a retrospective study of health insurer mergers.** I have suggested elsewhere that one approach to this issue would be for the FTC or the DOJ to conduct a study of consummated health insurer mergers. One of the significant accomplishments of the Bush administration was a retrospective study of consummated health insurance mergers by the Federal Trade Commission. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical tools for addressing health insurance mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.

6. **Recognizing that the insurer does not represent the consumer.** Although insurers do help to control cost, they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the

consumer interest, but rather exploit the lack of competition, transparency, and the opportunity for deception to maximize profits.

7. **Clarify the jurisdiction of the FTC to bring enforcement actions against health insurers.** Some may suggest that the FTC lacks jurisdiction over health insurance. I urge this Committee to ask the FTC to clarify their position on this issue. Is the claim of no jurisdiction the law or simply an urban legend? As I understand it, there is a limitation in Section 6 of the FTC Act that prevents the FTC from performing studies of the insurance industry without seeking prior congressional approval. This provision does not prevent the FTC from bringing either competition or consumer protection enforcement actions. There may be arguments that the McCarran-Ferguson Act limits jurisdiction, but that exemption is limited to rate making activity. In addition, some people might argue that the FTC's ability to attack anticompetitive conduct by nonprofit insurance companies might be limited under the FTC Act. The solution to this problem is simple, straightforward and critical. If the FTC lacks jurisdiction in any respect to bring meaningful competition and consumer protection enforcement actions against health insurers, Congress must act immediately to provide that jurisdiction. There is no reason why health insurance should be immunized from the Federal Trade Commission Act.

8. **Require transparency of health care intermediaries.** There is a need for transparency of all health care intermediaries, including health insurers, pharmacy benefit managers and group purchasing organizations. Transparency has two aspects: first, for the purchaser of services, there should be full and adequate transparency so they can determine that they are receiving the full value of services provided by these health care intermediaries; and second, for the consumer, there should be adequate transparency to evaluate the value of products purchased, such as health insurance plans. A good first step towards transparency is an amendment offered by Congressman Weiner to H.R. 3200 which requires transparency by PBMs which participate in plans in the health insurance exchange. Numerous consumer groups have endorsed the need for PBM transparency, and extending transparency to all health care intermediaries would allow for more informed decision-making by health care consumers and enhance competition in the markets for health insurers, PBMs and GPOs.[31] Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said, "I am a firm believer in what Justice Brandeis said in another context: Markets work better and attempted harms to competition are more likely to be thwarted when there is increased transparency to consumers and government about what is going on in an industry."

Conclusion

The current health insurance market suffers from anticompetitive and fraudulent activity practically unknown in any other market. If that market structure does not change, and these practices continue, the opportunity for meaningful reform will be severely diminished. Congress should continue its efforts to investigate these broken markets and the practices that plague

consumers. Congress should also act to assure that the full resources of federal antitrust and consumer protection enforcement are utilized to begin to reform these markets.

Endnotes

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