January 25, 2018

John Graham  
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Department of Health and Human Services  
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Washington, D.C. 20201

Submitted Electronically to CompetitionRFI@hhs.gov

Dear Acting Assistant Secretary:

The Council for Affordable Health Coverage (CAHC) is pleased to comment on the Request for Information on the January 20, 2017, Executive Order 13813 entitled “Promoting Healthcare Choice and Competition Across the United States.” CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests—organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations. As such, we appreciate the opportunity to comment on the Request for Information about policies that enable an operational, competitive and affordable US health market.

The Executive Order seeks to provide expanded coverage options, including Association Health Plans (AHPs), Short-Term, Limited-Duration Insurance (STLDI), and Health Reimbursement Arrangements (HRAs). Importantly, the EO also seeks to spur increased competition in healthcare markets by identifying and reducing or eliminating legal and other barriers to entry and improving access to and the use of information consumers need to make informed healthcare decisions, including data about healthcare prices and outcomes. We encourage you to take steps to eliminate federal policies that inhibit competition, drive up costs, and that make health coverage less affordable.

Background

Current federal and state policies, including those found in the ACA, have incentivized market consolidation across various health sectors. There is a wealth of evidence showing that consolidation and an imbalanced concentration of market power results in higher prices, lower quality, and less innovation.¹ These policies lead to higher costs and fewer choices. In 2016, 90 percent of metropolitan areas had highly concentrated hospital markets, 65 percent had highly concentrated specialist physician markets, 39

percent had highly concentrated primary care physician markets, and 57 percent had highly concentrated insurance markets.²

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

Both policy and (the lack of) enforcement have a quantifiable and negative impact. The U.S. health sector will take in more than $40 trillion over the next decade alone.³ Of that staggering sum, at least one-quarter ⁴—and perhaps more than one-half ⁵—will go toward services that are clinically unnecessary and sometimes dangerous.⁶ Meanwhile, prices for common tests and procedures typically are 3-5 times higher in the U.S. than in other developed countries,⁷ generally without yielding better outcomes.⁸ Spending growth in each year from 2012 to 2016 was almost entirely due to price increases, itself a reflection of weak competition.⁹

This very low customer value can be traced to uncompetitive health markets that have collateral effects on the macro economy, public finances and household living standards. By one widely used measure, health costs for the typical family of four rose from about 18 percent of the median family income in 2002 to 35 percent in 2017, a share that plausibly could exceed 50 percent early next decade.¹⁰ The growing diversion of employee compensation into health benefits has contributed to the decline in the median household (cash) incomes and rising income inequality.¹¹

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² Health Care Market Concentration Trends In The United States: Evidence And Policy Responses; Brent D. Fulton; Health Affairs 2017 36:9, 1530-1538
⁴ Institute of Medicine, “Better Care at Lower Cost: The Path to Continuously Learning Health Care in America,” published on-line, September 2012.
⁹ Health Care Cost Institute “2016 Health Care Cost and Utilization Report”
CAHC supports efforts to address these problems through reforms that will help increase competition, improve access, foster and expand informed consumer choice, promote value, and empower consumers. Congress and the Administration should work aggressively to expand and enhance competition and consumer choice and reduce statutory and regulatory burdens. Perhaps most importantly, decision makers should heed the threat posed by rising health costs.

Our comments are focused on the following areas:

1. The state and federal laws that reduce and restrict competition and choice in healthcare markets;
2. The state and federal laws that promote or encourage anticompetitive behaviors; and
3. Suggestions for policies and other solutions to promote the development and operation of a more competitive healthcare system.

We are calling on the Administration and Congress to make the following changes:

1. Improve price and quality transparency to empower consumers in plan and provider choices;
2. Expand and improve data to power private consumer transparency tools;
3. Allow consumers to vote with their feet by making premium subsidies portable;
4. Allow private eCommerce companies to compete to enroll consumers in health plans;
5. Expand plan choices, including account-based options;
6. Reform outdated laws that prevent value, care coordination and shared incentives to improve care;
7. Ban anti-competitive contract provisions that harm consumers and drive up costs, such as “anti-tiering” or “anti-steering” clauses; and
8. Reform Medicare policies that encourage care in higher cost settings.

These comments reflect the positions of CAHC, but may not necessarily reflect the individual views of our members.

Comments

I. Laws that reduce and restrict competition and choice in healthcare markets

It is disturbing that Congress and the Administration have enacted and pursued policies that limit competition and choice in healthcare markets. Ample evidence demonstrates these policies reduce consumer welfare, limit choices, and drive up costs for taxpayers.

Affordable Care Act: Plan choice and competition have declined under the ACA. Estimates indicate that more than one-third of consumers have just one issuer option on exchanges. The ACA has also significantly limited the types of plans available to consumers by restricting plan design and limiting subsidies to plans sold on public exchange markets. Some states have further reduced choices by
disallowing any plan design variation and/or prohibiting the sale of plans outside public exchanges. The law also requires subsidies to only be used for coverage of certain benefits at specific actuarial values.

Overly restricting plan design flexibility and choice limits the pool of consumers who may want to purchase coverage. It also hinders efforts to negotiate provider payment rates to lower costs for consumers. CBO has estimated that the essential health benefits (EHB), actuarial value (AV), and guaranteed issue requirements, alone, drive up costs by 27 to 30 percent. Both premiums and out-of-pocket costs are on the rise, and the ACA has tied consumers’ hands in their ability to utilize tax-preferred health accounts to cover these costs.

Perhaps most disturbing, the law requires consumers to use premium subsidies only on government sponsored exchanges and only for qualified health benefit plans, despite the presence of multiple private exchange competitors. The statutory monopoly exists even as HHS has tried to create more channel flexibility that recognizes the eCommerce strategy employed by HHS is decades or more behind the private sector.12

**Title XVIII (Medicare) Coverage and Reimbursement Policies:** Medicare payment policies often pay more for the same or similar services across different sites of care. For example, Medicare pays higher rates for evaluation and management codes in the hospital outpatient setting than in the physician office setting. Medicare statute also requires manufacturers to include prompt pay discounts in the calculation of Average Sales Price (ASP), which effectively reduces Medicare drug reimbursement for community providers who do not customarily receive these discounts. Conversely, these wholesaler prompt pay discounts are excluded from the calculation of Average Manufacturer Price (AMP), resulting in a discrepancy between these reimbursement methodologies. Telehealth reimbursement must be provided for and paid in an “originating site” – with an additional fee – rather than in a beneficiary’s home. It is illegal for beneficiaries who like and want to keep an HSA from carrying their private coverage into the Medicare program, making Medicare secondary while lowering taxpayer costs.

Medicare’s efforts to control costs center on rate-setting, as defined in statute and implemented via regulation. This emphasis on price channels provider energies into boosting volume and intensity, which Medicare only lightly manages. To this end, hospitals invest heavily in sophisticated facilities and specialist medical staff, who then over-prescribe to both public and private patients. This capital-intensive strategy also compels hospitals to consolidate. Hospital credit ratings depend in large part (and increasingly) on market factors, such as market share.13, 14 Among other things, market power allows hospitals to offset revenue losses from Medicare rate cutting by raising prices for private customers.

14 Ron Shrinkman, “Standard & Poor’s will revise ratings system for hospitals,” FierceHealthFinance, December 12, 2013.
While economists debate the prevalence of cost shifting—since, in theory, firms will always use their “reserve monopoly power”—hospitals claim it is widespread.\(^{15}\)

The effects of these flaws are felt most acutely by community-based providers, who do not have the ability or profit margins to absorb lower reimbursement rates. Multiple studies have illustrated that Medicare reimbursement policies are causing community-based practices to close their doors or integrate with larger health systems, affecting patient access and increasing costs. For example, more than 1,500 community cancer care centers have closed, consolidated, or reported financial problems since 2008. As a result, many patients have no choice but to access care in more expensive settings, sometimes at a great distance from their homes.

**Certificate of Need:** High barriers to market entry and the essential status of hospitals and physicians in community health infrastructures create a political rationale for policies designed to insulate health providers, particularly hospitals, from the free interplay of market forces. Barriers to entry are considerable: replacement costs for community hospitals typically run $200-500 million, while medical centers cost upwards of $2 billion.\(^{16}\) The closure of a facility in many communities may represent a permanent loss in capacity as well as the loss of jobs. To inhibit destructive competition, 36 states operate Certificate of Need programs. FTC gives unusual large credence to the “flailing or failing” merger defense, in which the stronger partner is deemed to rescue a weak partner, thus preserving capacity that might otherwise close down. Only about 1.5 percent of non-hospital antitrust cases feature this defense, but more than half of hospital merger cases do.

**Anti-Kickback Statute:** The law is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. While effective in reducing fraud, it also ignores changes in incentives via new models of care coordination. While market consolidation can lead to increased costs through an imbalance in power, greater alliance and care coordination can improve patient outcomes and increase value and efficiency without creating market imbalances that inhibit competition. Strategic alliances formally bring together separate, independent parties in pursuit of a common goal. Many recent policies in the Medicare program promote such alliances in the form of alternative payment models. But value-based purchasing arrangements for prescription drugs that include alliances between payers, biopharmaceutical manufacturers, and health care providers remain illegal, despite their increasing use in the private sector.

**Medicaid Best Price:** Congress enacted Section 1927(a) to require drug manufacturers to participate in the 340B program and give Medicaid the best price available in the market or pay a rebate to states. Prior to the law’s enactment, hospitals, HMOs and others often received 50 percent or more off their drug prices. After the law was enacted, discounts shrank for those private payers, and all but disappeared for the smallest purchasers, as manufacturers sought to limit financial payments to state programs. Rather

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\(^{15}\) For example, see on the American Hospital Association website: Margaret E. Guerin-Calvert and Guillermo Israilevich, “Assessment of Cost Trends and Price Differences for U. S.”, Compass Lexecon, March 2011.

than lowering drug costs, the law increased them and limited price competition. Best price remains a significant discouragement to moving to pay for patient outcomes versus paying for pills because if a drug maker and a plan enter an agreement to do so, the lower price becomes part of the “best price” scheme. This is why there are fewer than 250 contracts to pay for value in pharmaceuticals, while there are tens of thousands of pay for value programs for hospitals and doctors.

**340B Program:** Hospitals and other entities buy drugs through the 340B program at steep discounts, and argue these savings are passed on to low income patients and those without coverage. Significant data indicate this is not the case. Using arbitrage conveyed by the program, hospitals have engaged in a buying spree of independent physician offices, including hundreds of independent community oncology practices. These acquisitions reduce competition and choices for cancer patients and others in rural or underserved areas, while increasing taxpayer costs.

II. The state and federal laws that promote or encourage anticompetitive behaviors

**Most Favored Nation Status:** MFN is a specific contracting strategy that has garnered attention from State Attorneys General, which allows an insurer with substantial market share to enter into an exclusive contractual arrangement to get the best discounts offered by a provider in a certain geographic area. This allows the insurer to maintain a dominant market position. Typically, the contract language will state that the health insurer or payer of provider services will receive the lowest price that has been given to any other health insurer in the market. These types of contracts make it difficult for any insurer other than a dominant carrier to offer competing coverage as an affordable option to consumers.

**Gag clauses:** Gag clauses, in which dominant providers forbid insurers from including their prices in online comparison websites for policyholders limit consumer information and prevent discounting that leads to lower costs. At a minimum, such prohibitions should be a standard condition of merger approvals.

**Other Anti-Competitive Practices:** DOJ and FTC issued a tough-sounding antitrust statement when the ACA’s ACO regulations were issued. It advises ACO applicants “to avoid” certain (widespread) anticompetitive conduct including preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most favored-nation,” or similar contractual clauses or provisions. These practices prevent entry of competing firms, or prevent the growth of, or economies of scale in, competitors and should be banned across providers as anti-competitive.

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Transparency and Anti-Trust Guidelines: Even in the most competitive markets, the lack of usable information on price and quality prevents consumers from directing their business to efficient providers. Hospitals have 20,000-30,000 items in their “charge masters,” which consist of list prices charged mainly to those patients with the least market power. Health plans generally can negotiate much lower rates. While anti-trust guidelines permit health plans to provide comparative data to their members, they prohibit them from publicly posting actual prices, in the belief that doing so would discourage providers from giving secret discounts, thus diverging average prices. In other instances, hospitals have insisted on “gag-clauses” in their contracts that prohibit health plans from disclosing hospital cost and quality information to their members.

III. Suggestions to promote the development of a more competitive health system.

Price and quality transparency can help to control costs for the “silent majority” of relatively healthy consumers. Eighty-one percent of health spending is consumed by the 20 percent of the population that is most seriously ill and injured. Insurers and health care providers spread these costs onto the healthier 80 percent via premiums and prices (the latter, for example, reflecting cost shifting by hospitals). Historically, insurance has insured relatively healthy consumers from high provider charges, thereby fostering a preference for convenience over cost. Such a preference localizes health markets and enhances provider pricing power. For example, in a 2008 study examining a 2000 merger of hospitals located 2.5 miles apart in Berkeley and Oakland, California, FTC found that the merger had allowed the smaller of the two hospitals to raise its prices by 28.4 percent to 44.2 percent (for different insurers). This was despite the presence of 17 hospitals within a 20-mile radius. Enhanced pricing power is reflected in sometimes extreme price variation for routine tests and procedures.

More recently, however, large deductibles on exchange plans, the increased adoption of HSA eligible high deductible health plans, which expose consumers to price variation up to the deductible limit, and Value-based Insurance Design (VBID) plans has broadened the geographical “footprint” of markets for non-emergent, schedulable tests and procedures. For example, many consumers are willing to travel tens of miles to save on non-emergent tests and procedures.
of miles to save, say, $2,000 on a colonoscopy. Separately, consumers have become more familiar with online comparison shopping. In many metropolitan areas, the new willingness of consumers to comparison shop will create needed price competition across much wider geographic areas than historically have been the case.

To empower mobile consumers, we recommend the following:

i. Hospitals, testing centers and ambulatory clinics should post the average amounts paid and the average cash price for those without coverage for the most common tests and procedures.

ii. We recommend prohibiting “gag clauses,” in which dominant providers forbid insurers from including their prices in online comparison websites for policyholders. At a minimum, such prohibitions should be a standard condition of merger approvals.

iii. HHS should issue rules to prohibit information blocking and to promote interoperability. It is also important to establish standards to support comprehensive patient electronic data portability, including tests to assess vendor compliance with data access requests. Patients should be able to take their entire EHR with them (not just a summary) when changing physicians or seeing subspecialists and other providers.

Better data is a prerequisite for better comparative information tools. Commercial entities, including insurers and data analytics firms, should have greater access to both public claims and private quality data for the purposes of managing care and constructing effective online comparison-shopping tools for consumers. Relatively healthy consumers, who are mobile and price sensitive, need comparison shopping tools capable of showing, for example, the often-inverse correlation between quality and cost. Effective comparison-shopping tools must consider such complexities as risk-weighting and efficiency, which requires sophisticated data analytics.

To this end, we recommend:

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

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

iii. HHS should require standardized Medicaid/CHIP claims and require that data to be shared with Qualified Entities.
iv. We suggest ONC coordinate an effort to include claims data from federally-funded health programs, including TRICARE, VA, and FEHBP, in releases for analysis by Qualified Entities.

v. Strengthen the plan and enrollment data made available for the ACA’s health insurance exchanges. HHS should regularly release enrollment data by health plan, carrier, county, and state, just as it does for Medicare Advantage and Part D.

vi. Once large public data sets have been created, the marginal cost of providing those data to each additional user is relatively low. To facilitate the dissemination and use of public data, the federal government should charge no more than this marginal cost.

**Provide subsidy portability and let consumers vote with their feet.** Consumers can only access tax subsidies and credits for insurance coverage through publicly run exchanges even though on- and off-exchange markets must have a unified risk pool for premium setting. This policy not only distorts the markets and limits consumer choice, but it also prevents innovative practices in the private sector from reaching many consumers.

Consumers should have more and better options. In all states, qualified private exchanges, issuers, and brokers should be able to supplement public exchange alternatives. To do this, all beneficiaries should be able to take their tax credits and subsidies off the exchanges for the purchase of state-approved insurance products. This could spur innovation in the private sector to attract consumers that the current system is missing. It would also mean that marketing decisions and funding would be based, not on political or ideological decisions, but on market-based decisions to spur enrollment. This has the potential to accelerate access to and development of innovative tools to aid decision making, better target and engage consumers, and lower costs for taxpayers.

**Allow competition in online enrollment:** Total reliance on public exchanges and enrollment efforts have proven to be insufficient. The government has clearly struggled to build consistently functioning sites that both inform and ease the plan selection process. Despite the more than $5 billion spent to establish and maintain public exchanges, most have been operating below the state of the art in consumer accessibility and decision-support tools even though these tools are often found in the private sector.

HHS should contract out most functions of healthcare.gov and encourage states – via 1332 waivers and other mechanisms – to expand channels for enrollment, including through private exchanges and web sites. Ideally, healthcare.gov should become a federal data hub, where private exchanges would query the database to determine enrollment and APTC eligibility. Private web brokers, direct enrollment and exchanges would then facilitate enrollment into plans. HHS should not compete with private entities who are better equipped and suited to compete in eCommerce enrollment.
**Expand consumer choices in plan options:** Standardized plan designs can lead to reduced plan offerings, higher premiums and cost-sharing for certain consumers, and may influence suboptimal plan selection. Beginning in 2016, HHS designed plan offerings where a significant number of benefits were not subject to a deductible. HHS promoted these plans above others on HealthCare.gov, even though they may not have been the most appropriate plan designs for many enrollees. Such designs may unduly influence consumer behavior, further limit the number of tools available to insurers to hold down premiums, and force dramatic increases in cost-sharing for some services to meet AV thresholds. These designs can lead to higher premiums and reductions in access to services for some enrollees. HHS should prohibit state-based exchanges from either requiring plans to offer standardized plans or prohibiting plans that deviate from standard designs. Such policies not only lead to higher costs but also inhibit consumer choice.

**Encourage greater flexibility in benefit design to help manage conditions and meet diverse consumer needs.** The Administration should allow for and incentivize the creation of specialized plans that target and improve care for patients with high-cost conditions such as diabetes, mental health, and other illnesses. Because the exchange population has been shown to have greater medical needs than the general population, specialized plans can help insurers keep enrollees with higher cost conditions healthier, which can lower costs and premiums in a unified risk pool. Current non-discrimination rules may make it difficult for plans to offer such coverage, however. Additionally, these types of plans are not available to consumers in states such as California that prohibit variation from rigid standardized benefit designs. We urge the Administration to reform or repeal any policies impeding innovative benefit design.

**Improve and expand the use of consumer-driven health products.** Congress created these products, like HSAs and FSAs, partly to generate more awareness and control in health consumption while maintaining access to care. The ACA limited ways that consumer-driven health products can be used, which can drive up costs for consumers. The following changes will improve competition by giving consumers greater control over their health care:

1. The ACA prohibits individuals from using any remaining premium tax credit for the purchase of qualified health plans to be placed into an HSA. This creates powerful disincentives for consumers to choose lower-cost plans and place any left-over credit into an account for later use. Consumers should be allowed to use any remaining subsidy credits for HSA contributions.

2. The ACA prohibited the use of HSAs, FSAs, Archer Medical Savings Accounts, and Health Reimbursement Arrangements to purchase or be reimbursed for the purchase of over-the-counter (OTC) medications without a prescription. There are many lower-cost alternatives to prescription drugs available OTC, but the law requires patients who would like to use these tax-preferred mechanisms to either go to their physician for a prescription (where the visit would have to be reimbursed) for the OTC drug or get a prescription for a similar drug covered by insurance. Either scenario drives up costs for the insurer and the patient. Patients should be allowed to use consumer-driven health products for OTC medications.
iii. More flexibility should be given to the types of plans eligible for HSAs to meet more diverse consumer needs. Anyone facing a chronic condition will likely use all or most of their HSA funds annually with little or no funds to roll over to cover large medical expenses that may be incurred later. CAHC supports broader use of HSAs by individuals facing chronic conditions. Allowing HSA-eligible plans to provide first-dollar coverage for targeted treatments and preventive services that are clinically proven to improve health outcomes and prevent chronic disease progression would maintain appropriate access to necessary care. For example, such a plan could provide a diabetic patient with pre-deductible access to test strips, insulin, and diabetic eye exams. Reforming these rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits for many enrollees while also potentially reducing costs.

iv. Cost-sharing generates more awareness of health consumption, which can positively influence consumer behavior. To maintain access to care, lower-income individuals should have access to assistance to cover these obligations. Converting cost-sharing assistance subsidies into account-based plan deposits, putting health funds directly in the hands of consumers, would empower consumers to make better decisions, generate competition and promote good stewardship.

Pay for value: Health care is undergoing a monumental shift as payers move to aggressively reward value defined by lower costs and better outcomes. Bundled payments, accountable care organizations, evidence-based medicine, and VBID have become key tools in a system-wide movement away from traditional volume-based, fee-for-service payment models. In such value-based systems, payment for a service or treatment is linked to real medical outcomes, rewarding lower cost and higher quality – not quantity. Current law has inhibited this move in the prescription drug space, however.

Key reforms must be made to enable this shift toward value-based reimbursement. Ultimately, this kind of approach will more effectively encourage resources to be allocated to treatments that provide the most benefit at the lowest cost to consumers and society, enabling consumers and governments alike to make the most of their available resources.

i. Reform pricing models that inhibit value-based arrangements. Manufacturers and payers are reluctant to enter into value-based arrangements, in part, because of the challenge of squaring such innovative approaches with the inflexible complexities of rebate liabilities under Medicaid’s “best price” reporting requirements. Additionally, other drug reporting programs also hinge reimbursement on sales prices, which compounds the chilling effect on value-based systems by setting artificial pricing floors. The result is that many innovative, lower cost arrangements simply are not pursued. We recommend that clear exceptions to Medicaid best price, Average Sales Price, and Average Manufacturer Price reporting be established for value-based arrangements, coupled with clear guidance to reduce current ambiguity about how to capture value-based pricing for reporting purposes.
ii. Reform Anti-Kickback and Stark restrictions. The Anti-Kickback and Stark laws are intended to prevent fraudulent and abusive practices by prohibiting arrangements where organizations, individuals, and physicians could receive inappropriate payments for referring a product or service that would be paid for by federal health programs. Although the laws have historically been effective in capturing true misconduct, their broad and relatively inflexible approach has also had the unintended consequence of hampering the adoption of innovative arrangements and patient engagement efforts that can truly benefit consumers and the health care system. This is especially relevant to value-based and care coordination arrangements.

Remove barriers to competition by eliminating uncompetitive contracting practices. In the final rule establishing ACOs, the Federal Trade Commission identified several suspect practices that strengthen provider bargaining power at the expense of health plans and consumers. Consistent with this policy, Congress should nullify and prohibit contractual provisions preventing or discouraging competition. Contracts that prevent private payers from directing or incentivizing patients to choose certain providers, through “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most-favored-nation,” or similar contractual clauses would be prohibited. Tying sales to the private payer’s purchase of other services—for example, requiring an insurer to contract with all the hospitals under common ownership with a hospital or other provider entity—should also be prohibited.

i. Congress should ban anti-competitive arrangements that limit competition and decrease consumer welfare.

ii. Congress should provide the Department of Justice and the FTC additional resources to better promote competitive markets.

iii. DOJ and FTC should systematically review local markets and seek to improve competition in markets that are not competitive. DOJ and FTC should not rely on a prospective approach, but should seek to expand competition and consumer welfare in markets that today are highly concentrated.

iv. DOJ and FTC should more vigorously enforce the anti-trust laws in markets that are highly concentrated (anything with an HHI above 2500).

Regulate price setting in highly concentrated health markets. Monopoly prices create economic problems similar to administered prices, namely, distorting incentives and eliminating the disciplines of competition. Under this approach, hospitals and, where applicable, other providers would be constrained from practicing price discrimination among private payers in highly concentrated markets—requiring the affected providers to charge all private payers similar prices. This feature would reduce barriers to entry for new health plans. To combat excess cost growth, the proposal would create a regulatory framework similar to utility law. Local authorities in highly concentrated markets would be empowered to establish
regulatory bodies, analogous to utility districts, which could convene stakeholders, including providers, plans and consumers, in a public price-setting process. This “common carrier” approach recognizes that concentration has advanced too far nationally to fix through antitrust enforcement alone, and that in many communities, hospitals are natural monopolies with high barriers to entry. In addition to eliminating the business case for market consolidation, local “collective bargaining” tailors solutions to the size and circumstances of discrete health markets.

**Stem the Tide of Market Concentration.** Several federal policies proactively encourage provider market concentration, which leads to higher prices and costs. The playing field should be leveled by eliminating or reducing Medicare payment differentials between sites of care for the same or similar services, allowing beneficiaries to share in any savings generated by ACOs, and reforming the 340B drug discount program. Specifically, hospitals should be required to report how 340B discounts are used to provide charitable care and ensure rebates flow to consumers via lower costs. Finally, prompt pay discounts should not reduce reimbursement in ways that encourage community-based providers to integrate or sell their practices to hospital or health systems.

**Conclusion**

The stakes involved in promoting more competitive markets are considerable. Dartmouth Health Atlas estimates that 30 percent of health spending—more than $1 trillion in 2018—is “waste”. A reduction of this magnitude would raise worker incomes while substantially eliminating federal budget imbalances. Strengthening the business case for productivity may be the single most important object of health market reform.

CAHC appreciates your careful consideration of our comments. We stand ready to serve as a resource to you and your staff on the issues related to improving affordability, transparency, and empowerment for Medicare beneficiaries.

Sincerely,

Joel White
President