

Addendum to Testimony of Erin C. Fuse Brown, J.D., M.P.H.¹

Before the United States Senate Judiciary Committee
Subcommittee on Competition Policy, Antitrust, and Consumer Rights
Hearing on Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing
Economic Resiliency

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The Senate Judiciary Committee, Subcommittee on Competition Policy, Antitrust, and Consumer Rights requested further details and sought responses to the questions outlined in this document. The responses provided below were submitted for the official record.

Questions from Senator Hirono

In your testimony, you suggested that a “Glass-Steagall for healthcare” prohibiting payer-provider integration could help rein in out-of-control healthcare costs. This is an intriguing idea.

- **What do you view as some of the most pernicious forms of payer-provider integration?**

Response: There are two forms of vertical payer-provider integration that are particularly problematic. First, health insurers that own medical practices and pharmacies have both the opportunity and financial incentive to steer patients to their affiliated providers. Payers can use anticompetitive tactics and differential cost-sharing to self-preference their own affiliates, which drives independent practices and pharmacies out of the market. These tactics can reduce patients’ access, choice of provider, and disrupt longstanding care relationships. Second, when Medicare Advantage (MA) insurers acquire primary care and in-home providers, MA plans’ control over these providers allows the plans to aggressively capture and inflate beneficiaries’ diagnoses to increase risk-adjusted payments from Medicare. This type of vertical integration contributes to the rampant overpayment of MA plans relative to traditional Medicare and costs taxpayers billions of dollars.²

- **When payers merge with or acquire providers, they often cite efficiencies that will be created through their vertical integration. Is this an accurate way to look at the effect of payer-provider integration on healthcare markets and spending?**

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² Hayden Rooke-Ley, Medicare Advantage and Vertical Consolidation in Health Care, American Economic Liberties Project, Apr. 30, 2024, <https://www.economicliberties.us/our-work/medicare-advantage-and-vertical-consolidation-in-health-care/>; Medicare Payment Advisory Commission. January 2024 Status Report, January 12, 2024, <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>.

Response: It is very difficult to measure efficiencies created by vertical payer-provider consolidation. As a result, it is difficult to hold consolidated entities accountable if they fail to produce the promised efficiencies. For instance, entities claim that vertical integration will allow them to reduce administrative and purchasing costs, and coordinate patient care. However, vertical payer-provider integration also allows payers to hide profits and administrative costs by paying above-market prices to related provider-subidiaries, thereby evading Medical Loss Ratio requirements that are supposed to limit insurer profits and administrative costs to 15% of premium revenues. Moreover, intercompany transfers encourage consolidated payer-provider entities to overpay their own subsidiaries and underpay unaffiliated providers, which increases costs for patients and taxpayers and pushes independent providers out of business.³ Such intercompany transfers to related parties are one way that vertically consolidated payer-provider entities can obscure whether and to what extent they are achieving meaningful efficiencies and savings for consumers.

- **Should a *Glass-Steagall* for healthcare apply to affiliated not-for-profit managed care organizations and plans?**

Response: A *Glass-Steagall* policy that prohibits health insurance companies from owning providers, such as physician practices or pharmacies, would not necessarily impede a nonprofit, fully integrated staff-model Health Maintenance Organization (HMO) like Kaiser, in which the for-profit Permanente Medical Group employs the physicians and is a separate entity from the nonprofit Kaiser Foundation Health Plan. Nevertheless, a *Glass-Steagall* for health care could include limited exemptions for a fully integrated, nonprofit managed care entity, under which the insurance company, physicians, and patients agree that all care would be provided under one roof via a closed HMO network of employed or affiliated providers.

- **Do you believe such a law should apply only prospectively (to prevent future integrations), or should it require presently-integrated companies to be broken up?**

Response: Because so much payer-provider consolidation has already occurred, a structural solution like a *Glass-Steagall* for health care should apply retroactively as well as prospectively to create a level playing field. Otherwise, only prohibiting future payer-provider consolidation in the market would favor existing consolidated entities and disadvantage new market entrants and competitors.

There are reports of vertically-integrated health systems “steering” customers to insurers, providers, and pharmacies owned by the same conglomerates:

- **Do antitrust enforcers have sufficient tools to challenge anticompetitive steering practices?**

Response: Although steering practices could constitute unlawful monopolization under Section 2 of the Sherman Act or violate the Robinson-Patman Act (prohibiting certain forms of price discrimination), applying these laws to anticompetitive steering and self-preferencing by vertically consolidated entities is difficult in practice. Proving that steering or self-preferencing is unlawful under current antitrust laws requires showing the entity has market power in the specific product

³ Jared S. Hopkins, “Mail-Order Drugs Were Supposed to Keep Costs Down. It’s Doing the Opposite.” Wall Street J., June 25, 2024, <https://www.wsj.com/health/pharma/higher-drug-costs-mail-order-prescription-bf37886f>.

market and competitive harm results from the complete refusal to treat rivals equally.⁴ Moreover, the Robinson-Patman Act only prohibits discrimination among two independent purchasers, so it does not apply to self-preferencing by a vertically consolidated entity. In short, current antitrust tools are inadequate to curtail anticompetitive steering and self-preferencing by vertically integrated health care entities.

- **If so, are they being used effectively? If not, how can Congress empower antitrust enforcers to protect consumers from the harms of those practices?**

Response: Existing laws have not, to my knowledge, been used to address anticompetitive steering or self-preferencing by vertically consolidated payer-provider entities. Congress, and members of this Subcommittee, have recently proposed legislation to address self-preferencing in the online context in the American Innovation and Choice Online Act (AICOA), which among other provisions, would apply to unilateral self-preferencing and steering practices by large “gatekeeper” firms, judged by firm size rather than by market power in a particular product market. Importantly, the AICOA would cover subtler forms of steering and self-preferencing, not just complete refusals to deal with rivals. Provisions like those in the AICOA could be extended beyond online platforms to a broader range of businesses and steering practices, including the vertically integrated payer-provider entities in the health care industry. Moreover, the Robinson-Patman Act could be updated to address self-preferencing and anticompetitive price-discrimination between related entities, not just independent purchasers. Finally, because this conduct is so widespread, additional legal tools should be enforceable by federal and state antitrust authorities as well as by private parties harmed by the anticompetitive conduct.

⁴ Herbert Hovenkamp, “Antitrust and Self-Preferencing,” 8 Antitrust #1 (Fall 2023), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4526022.