

**Statement of David Balto, Senior Fellow**

**Center for American Progress Action Fund**

**Before the Consumer Protection, Product Safety and Insurance Subcommittee of the  
Senate Committee on Commerce, Science and Transportation**

**on “Competition in the Health Care Marketplace”**

**“The Effects of Regulatory Neglect on Health Care Consumers”**

**July 16, 2009**

Chairman Pryor, Ranking Member Wicker and other members of the Committee, I appreciate the opportunity to come before you today and testify about health care 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 that raises prices and costs for consumers and the American taxpayer, especially conduct by certain health care intermediaries – Health Insurers, Pharmacy Benefit Managers (“PBMs”) and Group Purchasing Organizations (“GPOs”).

This Committee, like the rest of Congress has been devoting considerable resources to health care reform. This Committee, under the leadership of Chairman Rockefeller, has led the way in making the public aware of the deceptive and fraudulent conduct of health insurers, particularly by shining a spotlight on the egregious activity of Ingenix, the United HealthCare subsidiary which has harmed thousands of patients and doctors by distorting the usual and customary rates of those health care providers. Thanks to the efforts of New York Attorney General Cuomo this fraudulent scheme activity is being reformed.

**The Problem of Regulatory Neglect**

I have a simple and vital message for this Committee: the Ingenix example is only the tip of the iceberg. The fundamental elements for a competitive market are transparency and choice and in both respects, health insurance markets are clearly broken. **Few markets are as concentrated, opaque and complex, and subject to rampant anticompetitive and deceptive conduct.** 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.

The Ingenix example is important for other supposedly important efforts at managing health care costs – PBMs and GPOs. Some suggest these entities serve an important function in controlling health care costs. But like the Ingenix example, they often are subject to deceptive conduct and conflicts of interest and can be used to forestall competition, rather than promote it. Again because of a lack of choice and transparency, and the existence of conflicts of interest, these intermediaries have failed to fulfill their mission and foster competition and choice.

The FTC has accomplished tremendous things with its enforcement actions in the health care sector over the past 50 years, from opening up the practice of medicine to innovative forms of practice, to challenging conduct that has impeded entry of generic drugs. In a recent paper for the Center for American Progress, I detailed the positive results of the efforts of the FTC in expanding access to affordable generic drugs. By taking action against the deceptive strategies which allow drug companies to artificially extend the life of their patent-protected drugs, the FTC has given consumers wider choice in the drugs available to them. Consumers save billions of dollars annually because of these efforts.

Unfortunately, the same attention has not been given to health insurers, PBMs, and GPOs. As I describe in my testimony much of the reason for the lack of competition and transparency, and the existence of conflicts of interest, is the failure of federal antitrust and consumer protection enforcement in the health insurance industry. During the Bush Administration, there were no enforcement actions against health insurers' anticompetitive, deceptive or fraudulent conduct. None. There was tremendous consolidation in the market, and the Justice Department simply required minor restructuring of two mergers. There were no cases against anticompetitive conduct by health insurers. There were no federal consumer protection enforcement actions. A similar record of regulatory neglect exists for PBMs and GPOs.

State enforcement officials have frequently tried to fill the void created by this regulatory neglect. State legislators have tried to reform these markets through legislation. When they have they often face the FTC as an adversary, repeating the theory that the best regulation is no regulation. In the PBM market, the only segment of the health care industry that is unregulated, a coalition of over 30 states brought 5 enforcement actions against the three major PBMs attacking deceptive conduct and securing over \$370 million in penalties and damages. When legislators have tried to enact legislation to address these problems in a comprehensive fashion, the FTC files letters opposing the legislation – opposing the efforts of consumer groups, unions, and other supporters of the legislation and taking the side of these firms that have engaged in these egregious anticonsumer practices. That makes no sense.

This record of regulatory neglect must be reversed. Health insurers, PBMs, and GPOs can play a vital role in controlling health care costs and facilitating health care reform. Their size affords them strong purchasing power, and these savings can, in turn, be passed on to consumers and plan enrollees, where there is adequate choice and transparency and protections against conflicts of interest. But these are for-profit entities whose first obligation is to the bottom line. Where the regulators are asleep at the switch, or there is a lack of adequate regulation, these firms will exploit that opportunity. Frequently, these firms engage in deceptive and fraudulent conduct, the purpose of which is to build profits rather than control costs. A lack of competition and consumer protection regulation and enforcement means that the rigor of the competitive market is absent.

Why is there an imbalance in enforcement and a lax position on the conduct of health care intermediaries such as insurers and PBMs? Perhaps that is because the agencies treat the insurer or PBM as if it is the consumer. If they do, that is a mistake. Insurers and PBMs do attempt to control costs for employers and other purchasers of health plans. While these entities may attempt to control cost they are also for profit entities with an overriding incentive to maximize profits. When there are battles between healthcare providers and insurers, the FTC always weighs in on the side of the insurers. But insurers are not the consumers. When there are battles between pharmacies and PBMs, the FTC always weighs in on the side of the PBM. But PBMs are not the consumers. Increasingly unions and consumer groups are raising the most serious concerns over the conduct of insurers and PBMs. When organizations like Change to Win, which represents over 10 million union members who have to pay the cost of health care, speak up against the egregious conduct of CVS/Caremark in a landmark study, it is time for the FTC to take notice. When consumer groups and public interest advocates speak up against the egregious conduct of insurers, or seek legislation to regulate PBMs, the FTC should recognize the legitimate representatives of the consumer interest.[\[1\]](#)

Are health insurers and PBMs an appropriate proxy for the consumer interest? Obviously the ability to manage health care costs is critical for plans, and the insurance companies and PBMs have the potential for aiding that process significantly. However, any objective perception of the results of health insurer and PBM activity over the past several years would severely question whether these entities truly do act in the interest of the ultimate consumers. As documented in the hearings this Committee has held in the past several months there are rampant anticompetitive and fraudulent activities by health insurers. The primary goal of these for-profit insurers and PBMs is to serve their shareholders and their profit margins, and not consumers. They are not the representative of the consumer interest.

My testimony proceeds as follows. I first describe how the competition and consumer protection missions of the FTC have failed to adequately address the problems of health care intermediaries, including health insurers, PBMs and GPOs. For each, I describe how a lack of competition enforcement has led to highly concentrated markets across the country and high costs for consumers. I identify significant anticompetitive practices by insurers, PBMs, and GPOs that have gone unchallenged. In addition, I describe how a lack of consumer protection enforcement has created an environment in which deceptive conduct has flourished. To a certain extent, state enforcers and private litigants have filled the void from the lack of enforcement on the federal level, but this is not an adequate substitute for federal enforcement. Finally, I provide several recommendations for reversing the regulatory neglect of these important markets. Enforcement priorities must be realigned to build a sound structure from which the FTC can pursue its health care competition and consumer protection missions.

**My recommendations include:**

- **Enforcement priorities should be readjusted with a greater focus on bringing enforcement actions against health insurers, PBMs and GPOs.**
- **The FTC should significantly increase health insurance consumer protection enforcement and create a separate division for health insurance consumer protection enforcement.**
- **The FTC should reinvigorate enforcement against anticompetitive conduct by health insurers, PBMs and GPOs, focusing on those which lead to higher**

- costs and increase entry barriers. The FTC should conduct a retrospective study of health insurer mergers to identify those which have harmed consumers.
- The FTC should take a more fully informed and balanced position on PBM advocacy, recognizing substantial enforcement actions brought by states against PBMs for fraud and deceptive conduct.
  - The enforcement agencies need to recognize that insurers and PBMs often do not reflect interests of consumers and that they are not true representatives of consumers.
  - Congress should clarify the jurisdiction of the FTC to be able to bring enforcement against health insurers.

### **Rampant Competitive and Consumer Protection Problems in Health Insurance**

Let me return to 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.”<sup>[2]</sup>

As I describe below there has been no meaningful federal antitrust or consumer protection enforcement against health insurers. 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.**

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% of the market, and in nine states a single firm that controls at least 75% of the market.<sup>[3]</sup> A 2007 AMA study found almost 95% of all markets are highly concentrated.<sup>[4]</sup> 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 Obama observed,

There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95% of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20% 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.<sup>[5]</sup>

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.<sup>[6]</sup>

Competition matters: A recent 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.<sup>[7]</sup>

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% 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.<sup>[8]</sup> Ultimately the Pennsylvania Insurance Commissioner reached the opposite decision and found such severe competitive problems that the parties were forced to abandon the acquisition.<sup>[9]</sup> It is not unusual for the states to step in where the federal enforcers fail to effectively challenge these mergers. As shown in appendix A, there have been several cases where state insurance commissioners have secured remedies even where the federal enforcers have failed to act.

Similarly, 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.

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.

The lack of enforcement was not due to a lack of resources, but a serious misjudgment in enforcement priorities. During the Bush administration the FTC spent a hugely disproportionate amount of time, money and effort prosecuting relatively small groups of doctors who impermissibly attempted to collectively bargain with insurers. It brought 31 enforcement cases against health care providers, frequently small groups of doctors. The disproportionate focus on physician groups seems somewhat puzzling. There was no evidence that higher physician costs were a significant force in increasing health care expenditures. In fact, one can scan the entire literature on rising health care costs and see little mention of efforts by physicians to collectively negotiate as being a substantial contributing factor to higher health care costs. All of these cases were settled, probably because of the high cost of being subject to a government investigation for these modest-sized groups of physicians. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did insurers or consumers file any antitrust suits seeking damages for the alleged illegal conduct.

Over 40% of the enforcement actions were in rural areas which often face significant problems of securing adequate providers. These enforcement actions only increased the problems of providing adequate access and service in these markets.

These comments are not intended to condone illegal conduct. But the missions of the enforcement agencies should be focused on those areas which have the greatest impact on the economy and consumers. And it seems relatively clear that the anticompetitive and deceptive conduct by health insurers has a far more profound impact.

The consumer protection story is also distressing. The hearings held by this Committee have demonstrated that consumers also face an astounding lack of transparency in the marketplace. Health insurance products are complex and terms are not uniform, making it near impossible for consumers to meaningfully compare their options. Insurers make special efforts to prevent transparency and information. **As Wendell Potter, a former insurance executive, testified before the full 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.”**[\[10\]](#)

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.[\[11\]](#) 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.[\[12\]](#) Consumers cannot access certain information about their benefits and insurers adjudicate claims based on inscrutable and even fraudulent formulas.

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 Health Care 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.[\[13\]](#) Numerous private suits continue.[\[14\]](#) 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.”[\[15\]](#)

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, how

do consumers fare? Let's examine Montana, where the single largest insurer, Blue Cross and Blue Shield of Montana, holds a 75 percent market share. According to a report by Health Care for America Now, the average annual combined premium for employers and employees in Montana rose from \$6,220 in 2000 to \$11,743 in 2007 – over half of that year's average annual salary in the state, \$22,170.<sup>[16]</sup> Montana is a leader in health insurer consolidation, but it is far from an outlier – similar markets exist in almost every state nationwide.<sup>[17]</sup>

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.

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.

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.”<sup>[18]</sup>

To combat this conduct, State Attorneys Generals, Insurance Commissioners, and private parties have brought over 50 cases securing potentially over \$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. As this Committee has heard, 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.<sup>[19]</sup> In addition, state laws serve at best as a patchwork quilt to address consumer protection issues. In addition, self-insured health care plans, which account for over 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.

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.”<sup>[20]</sup> 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.

### **Anticompetitive and Deceptive Practices by Pharmacy Benefit Managers**

PBMs can play an important function in health care markets by setting up pharmaceutical benefit networks and adjudicating pharmaceutical claims. But the same story of regulatory neglect is true for PBMs. The FTC has not challenged any PBM mergers, or anticompetitive or fraudulent conduct by PBMs. This is a particularly serious

concern since PBMs are the only segment of the health insurance market that is unregulated.

First, like the insurance market, there has been tremendous consolidation among PBMs. In the Bush Administration, there were several large PBM mergers, so the three major PBMs (CVS/Caremark, Express Scripts and Medco) now have over 80% of the national PBM market. The FTC has not undertaken any enforcement activity in the face of this market consolidation. In fact, the past two substantial PBM mergers – Caremark’s acquisition of AdvancePCS and CVS’s acquisition of Caremark – were approved without a significant investigation, despite leading to a significant increase in market power.<sup>[21]</sup> **While consumers have faced rapidly increasing costs and inadequate access to pharmaceuticals, from 2003 to 2007, the three largest PBMs—Medco, Caremark and Express Scripts—nearly tripled their annual profits from \$966 million to over \$2.7 billion.**

Today the Committee will hear testimony of the problematic conduct CVS has engaged in after acquiring Caremark. This combination of the largest pharmacy chain with the largest PBM poses significant competitive concerns. The pharmacist testifying today is not alone in expressing these concerns. Consumer groups including the Consumer Federation of American and US PIRG, Change to Win (a coalition of unions), and the National Legislative Alliance on Prescription Drugs (a bipartisan group of state legislators) have called on the FTC to investigate allegations of anticompetitive and deceptive conduct that have increased prices and reduced choices for consumers.

The concerns raised about the CVS/Caremark alliance bear a striking and disturbing resemblance to the Ingenix situation. In order for the health insurance system to function effectively, there needed to be an honest, independent broker to determine usual and customary rates. That was the purpose of Ingenix. United’s ownership of Ingenix, however, distorted that relationship and created a conflict of interest. That is why the New York Attorney General required the divestiture of Ingenix and the creation of a non-profit entity to perform its function. Similarly, CVS’ ownership of Caremark distorts Caremark’s incentive and ability to be an honest broker. There is a clear conflict of interest and an ability to manipulate the relationship to harm CVS’ rivals and consumers. Moreover, controlling health care costs and health care reform is dependent on PBMs being honest brokers. Caremark, because it is a CVS subsidiary, is unlikely to function as an honest broker.

More generally, PBM consumer protection issues have an important impact on the potential for the government to control health care costs, and for many of the issues that the government will struggle with in health care reform. As described in other testimony

presented to this Committee, today there is a significant lack of transparency in PBM markets. Because of this lack of transparency, PBMs are able to "play the spread" between pharmaceutical manufacturers, pharmacies and the health care plans. As the union coalition Change to Win noted, "A lack of transparency is one of the key problems in the pharmacy benefit management industry. For example, PBMs often charge the health plans they serve significantly more for the drugs than they pay the pharmacies that distribute the drugs to patients. PBMs also may switch patients to a drug other than the one their doctor prescribed sometimes a drug more expensive for the health plan and patient to take advantage of rebates the PBM receives from drug manufacturers, which are often hidden from the PBM's customers."<sup>[22]</sup> By playing the spread, PBMs can artificially decrease the level of reimbursement to pharmacies. This conduct is clearly similar to the types of fraudulent and deceptive conduct that United Healthcare engaged in with its Ingenix subsidiary.

The lack of PBM transparency harms the government's efforts at controlling health care costs. The House Committee on Oversight in Government Affairs recently held hearings on the lack of PBM transparency and its impact on federal governmental programs. Change to Win and numerous other witnesses testified that the lack of oversight and transparency have led to higher drug costs for the federal government. Change to Win in particular noted how the CVS/Caremark relationship deterred the ability to effectively control costs.

There are numerous other competitive concerns raised by PBMs. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. This is similar to the concerns raised over kickbacks in the GPO context. More recently there have been a series of acquisitions by PBMs to acquire specialty pharmaceutical companies. These specialty pharmaceuticals are higher-priced drugs that need special handling. After these acquisitions, many of these PBMs rapidly increased the price of these specialty pharmaceuticals.<sup>[23]</sup>

Yet there have been no FTC enforcement actions against anticompetitive or deceptive conduct by PBMs. As in the health insurance market, both private parties and states have attempted to fill the void. In the past four years alone, cases brought by a coalition of over 30 state attorneys general have brought several cases attacking unfair, fraudulent and deceptive conduct. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases listed below, resulted in over \$371.9 million in damages to states, plans, and patients so far.

- United States v. Merck & Co., Inc., [et.al](#) – \$184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- United States v. AdvancePCS (now part of CVS/Caremark) – \$137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- United States v. Caremark, Inc. – pending suit alleging submission of reverse false claims to government-funded programs.
- State Attorneys General v. Caremark, Inc. – \$41 million in damages for deceptive trade practices, drug switching, and repackaging.
- State Attorneys General v. Express Scripts – \$9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

A group of state attorneys general and the DOJ are continuing to conduct several investigations of the three major PBMs, and several private actions challenging their conduct have been brought by unions and other customers. The current concentration of the national full-service PBM market only exacerbates these problems, increasing the need for government enforcement and potential regulation of the industry.

PBMs’ promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. The dominant PBMs have been characterized by opaque business practices, limited market competition, and widespread allegations of fraud. As a bipartisan group of state legislators noted:

We know of no other market in which there have been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.<sup>[24]</sup>

In an important decision upholding state regulation of PBMs, one federal court observed “[w]hether and how a PBM actually saves an individual benefits provider

money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider.” The court elaborated:

This lack of transparency also has a tendency to undermine a benefits provider’s ability to determine which is the best among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.<sup>[25]</sup>

Some of the problematic practices challenged in these cases include:

- secretly retaining most manufacturer payments, e.g., rebates, discounts and other fees, instead of passing through such payments to clients;
- switching plan members from low- to high-cost drugs;
- favoring higher-cost drugs on their formularies;
- manipulating generic (maximum allowable cost) pricing;
- entering into exclusivity arrangements with specialty pharmaceutical manufacturers that raise the prices of those drugs;
- conspiring with manufacturers to violate Omnibus Budget Reconciliation Act and “best pricing” regulations; and
- committing other contract or fiduciary breaches.

One chronic problem with PBMs is that of self-dealing. Plan sponsors purchase PBM services with the assumption they are an “honest broker” that will select the lowest cost, best product on an objective basis. These concerns of self-dealing were part of the

reason the FTC challenged the acquisition of PBMs by pharmaceutical manufacturers in the mid-1990s – Merck’s acquisition of Medco and Lilly’s acquisition of PCS. The concern was that the pharmaceutical manufacturers would favor their own drugs on the PBM formulary. These cases were resolved with orders that protected plan sponsors from the risks of self-dealing.

Unfortunately, these problems of self-dealing have continued to exist for PBMs. Almost all PBMs have their own mail order operations. Often, PBMs may favor drugs in which they receive a greater margin because they are dispensed by mail order, even though the plan sponsor or consumer may pay more. PBMs often seek to drive consumers to more highly profitable mail order distribution and away from independent pharmacies that offer the level of quality, advice and personal service consumers prefer. Consumers often suffer from the conversion to mail order: they are given little choice, there is a greater chance of adverse medical reactions, and there is little if any consumer service. Any consumer who has spent hours on the phone waiting for an answer on a mail order prescription sees little “efficiency” from these efforts to drive independent pharmacies from the market. Although an FTC study appeared to find little evidence of these problems of self-dealing, recent state enforcement actions have demonstrated that these problems are ongoing.

This problem of self-dealing has worsened with the acquisition of PBMs by major pharmaceutical chains. These chains may use the information secured through their PBM operations to target other pharmacies, by attempting to steal customers. At times the PBMs owned by chain pharmacies have attempted to deceive consumers to drive them from their rivals.

Unfortunately, the FTC has failed to investigate or take any enforcement action against this anticompetitive, fraudulent, and deceptive conduct. Even more troubling, in response to the substantial deceptive and fraudulent conduct uncovered in these state enforcement actions, several state legislatures have considered legislation to regulate PBMs. Many of the proposed statutes: (1) require transparency so the health plans can secure adequate information so they can receive the full benefits of any rebates paid to the PBM and (2) establish a fiduciary duty between the PBM and a plan to address the problems of conflicts of interest and self-dealing. When states have attempted to regulate PBMs to address the lack of enforcement, increase transparency or address forms of this deceptive conduct, the FTC has advocated on the side of the PBM industry in opposition to the proposed legislation. This is a mistake. As the American Antitrust Institute report to the Obama transition team observed: “[c]onsidering the substantial number of enforcement actions and the severity of the PBM conduct, we believe these efforts at regulating PBMs are well founded and that the FTC’s advocacy has been ill-advised.”<sup>[26]</sup>

In many cases the FTC has placed itself in opposition both to consumer groups and union plan sponsors which support the legislation. Opposing efforts to reign in conflicts of interest and improve transparency seem questionable. If there is anything the Ingenix example must teach us, it is that there is a significant potential for fraud and deception by health care intermediaries. Efforts to either clarify the duties of those intermediaries by establishing legal provisions making it clear they have a fiduciary duty to the plans, and providing adequate transparency so that plans can effectively monitor the PBMs' activities, would seem to be crucial elements for managing and controlling health care costs.

### **Anticompetitive Conduct by Group Purchasing Organizations**

GPOs negotiate contracts on behalf of their member hospitals with numerous entities, including medical device manufacturers. The original purpose of GPOs was to obtain better pricing on products than hospitals could obtain individually, and to provide value-added services. Although GPOs have the potential to reduce purchase costs by giving hospitals greater bargaining power, growing GPO consolidation and market power has increased the exclusionary potential of some of the GPO contracting practices.<sup>[27]</sup> Moreover, the payment of kickbacks is pervasive and undermines the product selection system.

Many small medical device manufacturing start-ups have demonstrated that contracting practices by GPOs have effectively foreclosed them from entering the market. Examples of alleged exclusionary practices include kickbacks, sole-source contracts, market share discounts, auto-substitution and bundling of products so hospitals must purchase the bulk of their supplies from a single vendor to qualify for a discount on any one product. Small manufacturers argue that incumbent suppliers, together with GPOs, use these practices to eliminate competition and preserve their market share.<sup>[28]</sup>

Particularly problematic are kickbacks paid by manufacturers to the GPOs. These kickbacks deceive buyers and third parties (including government entities) that are responsible for payment for the products of the real costs of the products. They may distort demand and provide the opportunity to artificially increase prices. Although there are regulations that prohibit kickbacks in many health care markets, the GPO payments fall into a safe harbor. In the past seven years, the Senate Judiciary Committee has held four hearings concerning kickbacks and other exclusionary conduct by GPOs. The FTC also addressed the issue in its 2003 health care competition hearings.<sup>[29]</sup> Over a dozen private suits have been brought, some successfully, by small innovative medical device

manufacturers against exclusionary practices by GPOs and device manufacturers.<sup>[30]</sup> Yet the FTC has failed to bring any enforcement actions in this area.

That is particularly unfortunate because of the FTC's unique statutory powers. The FTC brings competition enforcement actions under Section 5 of the FTC Act which prohibits "unfair or deceptive acts or practices." Section 5 is broader than the more traditional antitrust laws and enables the FTC to attack practices or conduct that are not necessarily a violation of the Sherman or Clayton Act.

Section 5 may provide a useful tool in two respects to cure the harmful practices in the medical device market. First, to the extent that potential enforcement actions against market share discounts, or other forms of de facto exclusivity seem deficient for some element necessary for a Sherman Act challenge, Section 5 may enable the FTC to overcome that deficiency. Second, the practices of kickbacks can be addressed under Section 5 as an unfair method of competition. A gap in enforcement currently exists because of the difficulty in proving that a kickback scheme constitutes a violation of the Sherman Act. The Ninth Circuit, after acknowledging the existence of a kickback scheme by an alleged health insurance monopolist caused higher co-payments and premium payments, found no antitrust violation because of a lack of evidence of harm to the relevant market.<sup>[31]</sup> Carried to its logical extreme that decision would mean that the antitrust laws would not prevent every insurance company from engaging in kickbacks that raised costs to consumers. However, under Section 5 a kickback scheme could be an unfair method of competition, particularly where there is evidence of consumer harm. The FTC should use Section 5 to challenge these kickbacks.

More generally, Congress needs to address the GPO kickback issue. Congress created a "safe harbor" from the Medicare anti-kickback statute in 1987, permitting dominant suppliers to pay billions of dollars to GPOs. These payments are often used to exclude competitors resulting in increased cost and decreased quality of medical devices over the past two decades. In order to restore competition in the procurement of medical supplies, this safe harbor must be repealed and suppliers must no longer be permitted to fund the GPOs.

As a 2002 GAO reports suggests, GPOs have evolved from neutral buying units to "gateways" which permit manufacturers to enter into arrangements that may raise entry barriers, ultimately leading to higher prices and less innovation. The report noted that "a manufacturer dominant in a product line may contract with a GPO, or agree to a favorable contract, to preserve its market share and exclude competition."

Sole-source contracts, exclusive-dealing relationships and bundling or rebate programs are not necessary for hospitals to obtain costs savings and can cause market inefficiencies. In fact, the GAO found in its 2002 pilot study that in a number of instances “GPOs’ prices were not always lower and were often higher than prices paid by hospitals negotiating with vendors directly.” The GAO’s follow-up report in 2003 concluded that “when used by GPOs with a large market share, these contracting strategies have the potential to reduce competition .... [and] discourage other manufacturers from entering the market.”

Besides greater antitrust enforcement, Congress should repeal the kickback safe harbor that permits GPOs to engage in this conduct that harms consumers and competition.

### **Recommendations for Revitalizing Competition and Consumer Protection Enforcement**

1. **The FTC should change the enforcement priorities to focus on the segments of the market with the greatest potential for harm: health insurance, PBMs and GPOs.** The areas of the market which seem to pose the greatest competitive problems are health care payment intermediaries, such as insurers and PBMs. These are the entities which operate in the most concentrated markets, and the complexity 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 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 FTC also needs to reinvigorate enforcement against anticompetitive conduct by health insurers, PBMs, and GPOs. 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 and PBM merger enforcement.** During the Bush administration there was significant consolidation in both of these markets, and now these markets are incredibly concentrated. 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 either health insurance or PBM 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 provide a valuable service in helping to clarify the appropriate legal standards for health insurance mergers and identifying mergers that have harmed competition.
  
6. **Greater studies of competitive problems in health insurance.** The FTC performs an important function in providing studies on key public policy issues. The FTC should provide studies on health insurance and begin its efforts with a long-overdue examination of the McCarran-Ferguson exemption, the elimination of which would increase the potential for competition between insurance companies in health insurance and in other areas.
  
7. **A more fully informed and balanced position in advocacy.** In many cases the FTC has placed itself in opposition both to consumer groups and in union plan sponsors in proposed legislation to regulate PBM markets by improving transparency and giving plan sponsors tools to prevent conflicts of interest. As a

general matter, I question the FTC's approach about criticizing proposed legislation seeking greater transparency and preventing conflicts of interest. If there is anything the Ingenix example must teach us, it is that there is a significant potential for fraud and deception by health care intermediaries. Efforts to either clarify the duties of those intermediaries by establishing legal provisions making it clear they have a fiduciary duty to the plans, and providing adequate transparency so that plans can effectively monitor the PBMs' activities, would seem to be crucial elements for managing and controlling health care costs.

**8. Recognizing that the insurer and the PBM do not represent the consumer.**

Although insurers and PBMs 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 and PBMs 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.

**9. Clarify the jurisdiction of the FTC to bring enforcement actions against health insurers.**

Some people 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. 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. Nor is there any reason why the failure to deploy enforcement resources should create a de facto exemption from antitrust or consumer protection enforcement for insurers or PBMs.

## **Conclusion**

Ultimately, the current health insurance and PBM markets suffer from anticompetitive and fraudulent activity practically unknown in any other market. The current market structure and the control of health care payment systems by for-profit entities raise serious questions if meaningful reform can ever be accomplished.[\[32\]](#) At

least we should start by assuring that the full resources of federal antitrust and consumer protection enforcement are utilized to begin to reform these markets.

Before it is too late.

---

[1] In the Bush Administration there was a mixed record, at best, in securing the input of consumer groups in important policy issues. In the FTC/DOJ hearings on dominant firm conduct there was no testimony from consumer groups. In the FTC hearings on collaboration by healthcare providers, the FTC declined participation by consumer groups.

[2] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses." May 2009. Available at [http://hcfan.3cdn.net/dadd15782e627e5b75\\_g9m6isl1.pdf](http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isl1.pdf)

[3] *ibid*

[4] American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2007 Update."

[5] Statement of Senator Barack Obama for the American Antitrust Institute, September 27, 2007. Accessed at [http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07\\_092720071759.pdf](http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf).

[6] Senator Patrick Leahy. Statement before the Senate Judiciary Committee Hearing: "Examining Competition in Group Health Care." September 6, 2006. Accessed at [http://judiciary.senate.gov/hearings/testimony.cfm?id=2046&wit\\_id=2629](http://judiciary.senate.gov/hearings/testimony.cfm?id=2046&wit_id=2629).

[7] Dan Vukmer, General Counsel, University of Pittsburgh Medical Center Health Plan. Statement before the Commonwealth of Pennsylvania House of Representatives Insurance Committee. Public Hearing on Proposed Merger between Independence Blue Cross and Highmark. August 25, 2008.

[8] Ario, Joel. "Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation." January 22, 2009.; Balto, David. Testimony before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights. "Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?" July 31, 2008.

[9] Von Bergen, Jane M. and Angela Coulombis, "Insurers IBC, Highmark withdraw merger plan." The Philadelphia Inquirer, January 15, 1990, accessed at <http://www.philly.com/philly/news/homepage/38128494.html>.

[10] Wendell Potter. Statement before the U.S. Senate Committee on Commerce, Science & Transportation Hearing: "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009. Accessed at <http://commerce.senate.gov/public/ files/PotterTestimonyConsumerHealthInsurance.pdf>.

[11] Letter from Jamie Court and Jerry Flanagan, Consumer Watchdog, to House Members Nancy Pelosi, Henry Waxman, George Miller, Pete Stark and Charles Rangel and Senators Max Baucus, Ted Kennedy, and Chris Dodd (June 4, 2009). Accessed at <http://www.consumerwatchdog.org/resources/PatientsBillOfRightsHouseSenate.pdf>.

[12] Fogoros, Richard N. "Why Gag Clauses are Obsolete." The Covert Rationing Blog, June 20, 2007. Accessed at <http://coverrationingblog.com/gekkonian-rationing/why-gag-clauses-are-obsolete>.

[13] Cook, Bob. "Final health plan reaches settlement over Ingenix database." American Medical News. July 6, 2009. Accessed at <http://www.ama-assn.org/amednews/2009/06/29/bisc0629.htm>.

[14] Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations. "Underpayments to Consumers by the Health Insurance Industry." Staff Report for Chairman Rockefeller. June 24, 2009.

[15] Senator John D. Rockefeller, IV, Remarks at the Senate Judiciary Hearing: Part II: Deceptive Health Insurance Industry Practices: Are Consumers Getting What They Paid For?" (March 31, 2009). Accessed at [http://commerce.senate.gov/public/index.cfm?FuseAction=Hearings.Statement&Statement\\_ID=8704a1ba-d058-4ad6-b6ff-3031bd2f0aef](http://commerce.senate.gov/public/index.cfm?FuseAction=Hearings.Statement&Statement_ID=8704a1ba-d058-4ad6-b6ff-3031bd2f0aef).

[16] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses." May 2009. Available at [http://hcfan.3cdn.net/dadd15782e627e5b75\\_g9m6isl1l.pdf](http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isl1l.pdf).

[17] Center for American Progress Action Fund. "Every State Needs Health Care Reform: 50 State Fact Sheets." July 7, 2009. Accessed at [http://www.americanprogressaction.org/issues/2009/07/health\\_factsheets.html](http://www.americanprogressaction.org/issues/2009/07/health_factsheets.html).

[18] Bell, Charles, Program Director, Consumers Union. "Testimony Before the Committee on Commerce, Science and Transportation, U.S. Senate, Hearing on Consumer Reimbursement for Health Care Services." March 26, 2009.

[19] Karen Pollitz. Statement before the U.S. Senate Committee on Commerce, Science & Transportation Hearing: "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009. Accessed at Wendell Potter. Statement before the U.S. Senate Committee on Commerce, Science & Transportation Hearing: "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009. Accessed at <http://commerce.senate.gov/public/ files/PotterTestimonyConsumerHealthInsurance.pdf>.

[20] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009. Accessed at [http://www.medpac.gov/documents/Mar09\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar09_EntireReport.pdf).

[21] The American Antitrust Institute provided a white paper assessing the structural issues posed by the proposed Express Scripts/Caremark merger. See American Antitrust Institute, *Express*

*Scripts' Proposed Acquisition of Caremark (2007)*, available at <http://www.antitrustinstitute.org/archives/files/>

AAI\_Express%20Scripts\_Caremark\_2-14\_021520071110.pdf. The law firm that represented one of the parties in the Caremark/AdvancePCS merger observed that the investigation was closed on a “quick look” review. See Jonesday.com, Experience Details: Caremark, [http://www.jonesday.com/experience/experience\\_detail.aspx?exID=S9298](http://www.jonesday.com/experience/experience_detail.aspx?exID=S9298) (last visited July 1, 2008). The CVS/Caremark merger was resolved without the FTC’s issuing a second request.

[22] Change to Win. Letter to Chairman Lynch and the members of the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform. June 24, 2009. Available at <http://federalworkforce.oversight.house.gov/documents/20090625153554.pdf>.

[23] Freudenheim, Milt. “The Middleman’s Markup.” The New York Times. April 19, 2008. (Attachment C)

[24] Letter from Mass. State Senator Mark Montigny to FTC Chairman Deborah Platt Majoras. May 11, 2005. (Attachment D).

[25] Pharm. Care Mgmt. Ass’n v. Rowe, 2005 U.S. Dist. LEXIS 2339, at \*7-8 (D. Me. Feb. 2, 2005), *aff’d*, 429 F.3d 294 (1st Cir. 2005).

[26] The Next Antitrust Agenda: The American Antitrust Institute’s Transition Report on Competition Policy to the 44<sup>th</sup> President (Albert A. Foer ed., 2008).

[27] See *Hospital Group Purchasing: Has the Market Become More Open to Competition?: Hearing Before the S. Comm. on the Judiciary*, 107th Cong. 3 – 4 (2003) (statement of Lynn James Everard).

[28] See, e.g., *Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovation?: Hearing Before the S. Comm. on the Judiciary*, 107th Cong. (2002) (statement of Joe E. Kiani, President and CEO, Masimo Corp.).

[29] FED. TRADE COMM’N, HEALTH CARE AND COMPETITION LAW AND POLICY PUBLIC COMMENTS (2003), available at <http://www.ftc.gov/os/comments/healthcarecomments2/index.shtm>.

[30] See *Masimo Corp. v. Tyco Healthcare Group, LP*, Case No. 02-CV-4770 (C.D. Cal. 2002). See also *Genico, Inc. v. Ethicon, Inc.*, No. 04-CV-00229 (E.D. Texas 2004); *Rochester Medical Corp. v. C.R. Bard Inc.*, Case No. 5:04-CV-060 (E.D. Tex. 2004); *Applied Med. Res. Corp. v. Johnson & Johnson, Inc.*, No. 03-CV-1329 (C.D. Cal. 2003); *ConMed Corp. v. Johnson & Johnson, Inc.*, No. 03-CV-8800 (S.D.N.Y. 2003); *Medtronic AVE Inc. v. Cordis Corp.*, Case No. 03-CV-212 (E.D. Tex. 2003); *Retractable Techs., Inc. v. Becton Dickinson & Co.*, Case No. 5:01CV00036 (E.D. Tex. 2001); *Kinetic Concepts, Inc. v. Hillenbrand Industries, Inc.*, Case No.5:95CV00755 (W.D. Tex. 1995).

[31] See *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1477-79 (9th Cir. 1997) (rejecting a claim that an insurance company’s alleged kickback scheme caused antitrust injury to group health insurance customers where the evidence showed the scheme caused higher co-payments and premium payments, but did “not explain how the scheme reduced competition in the relevant market”), *aff’d on other grounds*, 525 U.S. 299 (1999).

[\[32\]](#) In a forthcoming paper I argue that the public plan is necessary for meaningful reform of health insurance markets.