COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

May 27, 2025

Assistant Attorney General Abigail Slater
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Comment on the Department of Justice's Launch of the Anticompetitive Regulations Task Force (Docket No. ATR-2025-0001)

Dear Assistant Attorney General Slater,

The Council for Affordable Health Coverage (CAHC) appreciates the opportunity to provide comments to the Department of Justice's Anticompetitive Regulations Task Force (ARTF). As a broad-based coalition of employers, insurers, patient groups, and other stakeholders committed to expanding access to affordable coverage through market-based solutions, we commend the Department's recognition that government regulation itself can create or entrench anti-competitive conditions.

CAHC works to unburden consumers by advocating for policies that improve competitive markets, lower costs, and expand consumer choices. We support the Department's efforts to investigate and address laws and regulations that impede competition and innovation in health care, and make the following recommendations:

1. Reform Practices that Prevent Robust Competition
2. Expand Enforcement Against Anti-Competitive Actors and Practices
3. Empower Informed Consumers With Transparency
4. Help Low Income Working Americans, Not Big Health Systems

Our comments outline a number of reforms that cross jurisdiction with FTC because both the FTC and DOJ have important, overlapping roles to play in protecting and restoring competition to health care. Our views reflect those of CAHC, and not necessarily those of our individual members.

Background and Urgency

Health care is one of the most heavily regulated industries, and the burden too often impedes the doctor-patient relationship and competitive markets. For too long, a complex web of federal and state regulations has contributed to market consolidation, limited consumer choice, and increased costs across the health system. Meaningful reduction in health care costs can only be achieved if both public and private actors work to empower consumers, promote transparent pricing, and expand competitive markets.

The U.S. health care sector will collect more than $50 trillion over the next decade.[1] A substantial portion—at least one-quarter[2]—will pay for services that are clinically unnecessary or inefficient. Much of this is attributable to regulatory distortions and market consolidation that weaken competition, raise prices, and limit access. Highly concentrated provider markets have enabled hospital systems to charge rates far above what

[1] How much is health spending expected to grow? - Peterson-KFF Health System Tracker

[2] Shrank, WH (Shrank, William H.) ; Rogstad, TL (Rogstad, Teresa L.) ; Parekh, N (Parekh, Natasha), " Waste in the US Health Care System: Estimated Costs and Potential for Savings" accessed at Waste in the US Health Care System: Estimated Costs and Potential for Savings | Health Care Quality | JAMA | JAMA Network. Also see Institute of Medicine, "Better Care at Lower Cost: The Path to Continuously Learning Health Care in America," published on-line, September 2012.

would be expected in a functioning market, often 3–5 times higher than those in comparable developed nations, with no corresponding gains in quality or outcomes.[3]

Current law, regulations, and lax enforcement have allowed market power to accumulate unchecked, particularly among hospitals, large provider systems, and dominant insurers. As of 2024, more than three quarters of physicians are employed by hospitals or corporate entities, reflecting the decline of independent medicine.[4] 97 percent of hospital markets and 95 percent of insurance markets are highly concentrated.[5] Studies have shown that prices in highly concentrated hospital markets can be more than 20% higher than in more competitive markets.

Suggestions

We suggest the Trump Administration focus on laws and regulations that benefit monopolists at the expense of consumers.

A. Reforming Practices that Prevent Robust Competition

The relaxation of antitrust guidelines in 1992, 1994, 1996 and 2011—and court rulings based on now-disproven behavioral theories—has facilitated the massive consolidation in local health services markets. Nearly all (97% of) metropolitan areas had highly concentrated markets for inpatient hospital care.[6] As in other industries, a central motive for consolidation is pricing power. The prices charged to private patients are determined through annual negotiations between insurers and myriad providers in thousands of local markets. Insurers' ability to hold down prices depends on their ability to exclude high-cost providers when forming networks. Market concentration turns this process on its head, giving high-cost providers the ability to exclude low paying insurers.

Eighty-three 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. Historically, insurance has inured 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 seventeen hospitals within a 20-mile radius.[7] Enhanced pricing power is reflected in sometimes extreme price variation for routine tests and procedures, backed by the power of contracts that inhibit competition.[8,9]

Congress should nullify and prohibit contractual provisions preventing or discouraging competition and beef up FTC enforcement. 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 should be prohibited. Horizontal consolidation across markets allows hospital systems to us their dominance in one market to boost prices in others. This, too, should be prohibited.

1. ***Ban gag clauses in contracts between plan administrators and medical providers.*** Contracts between group health plan administrators and hospitals often contain clauses that prevent the

[3] International Federation of Health Plans, International Healthcare Cost Comparison Report 2024 – iFHP December 2024.
[4] Employed physicians U.S. 2024| Statista
[5] 95% of U.S. health insurance markets are "highly concentrated" | American Medical Association
[6] One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022 | KFF
[7] Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," Federal Trade Commission Working Paper No. 293 (November 2008): 20-26.
[8] Paul B. Ginsburg, Wide Variation in Hospital and Physician Payment Rates—Evidence of Provider Market Power," Research Brief No. 16 *Center for Studying Health System Change* (November 2010): 5-6.
[9] Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, March 16 2010: 3-4, 17-40.

administrator from disclosing hospital prices to the plan sponsor. That means that employers who are paying the claims do not know the prices the hospitals are charging for these claims.

2. ***Ban anti-steering clauses in contracts.*** Contracts between medical providers and health plans and issuers often contain clauses that prevent insurers from steering enrollees to providers that offer the best value. That means an insurer cannot tell an enrollee that it would cost less to get scheduled care at, for example, a freestanding ambulatory surgical center than at a hospital outpatient department.

3. ***Ban anti-tiering clauses.*** Contracts between medical providers and health plans and issuers often contain clauses that prevent insurers from creating cost-sharing tiers for such providers. These are somewhat analogous to drug formularies. PBMs can put one drug in a therapeutic category in a preferred tier, where patient copays are lower than for other drugs in that same therapeutic category. Plans and issuers should have the same latitude with respect to providers, charging lower copays for those that agree to lower prices. This would give enrollees incentives to seek care from providers in the preferred tiers and induce providers to offer better prices. A ban on these clauses should take effect on a date certain to ensure that they apply to multi-year and evergreen contracts.

4. ***Ban all-or-nothing clauses.*** Hospital conglomerates often include campuses in a variety of settings, including rural towns. An insurer that wants to contract with a rural affiliate of such a conglomerate can be contractually required to contract with all its affiliates. This immunizes the conglomerate from price competition. Such a ban should take effect on a certain date to ensure that they apply to multi-year and evergreen contracts.

5. ***Certificate of Need (CON) Laws.*** Thirty-six states operate CON programs that create structural barriers to entry and artificially insulate incumbents from competitive pressure. These laws reduce consumer choice, suppress innovation, and raise prices by shielding dominant market players from competition. The DOJ should work with FTC to address competition issues due to CON laws.

B. Enforcement

Considering the incredible concentration in health markets, we urge the DOJ and FTC to take a fresh look at competition and enforcement strategies. The reforms outlined below may require Congressional approval.

In addition, the DOJ and FTC should make clear that removal of the offensive clauses listed above does not shield providers from antitrust scrutiny. Banning such clauses has diminished effectiveness in markets dominated by vertically and horizontally integrated hospital systems. These systems warrant DOJ and FTC scrutiny, and the Administration should make clear that removal of offensive clauses from their contracts does not immunize them against such scrutiny.

1. ***Network Adequacy:*** HHS should allow telemedicine services for appropriate provider types (such as behavioral health) to count in meeting network adequacy requirements for Medicare Advantage, Medicaid Managed Care Organizations, Qualified Health Plans in the ACA. Such a policy could improve patient access, promote provider competition, and lower prices and costs.

2. ***Non-Profits:*** FTC should be given the power to investigate and enforce against anti-competitive practices by non-profit entities. Currently, about half of US hospitals are not-for-profit organizations. Currently, the FTC can review all hospital mergers but is barred from enforcing antitrust laws against what it deems to be anticompetitive practices of nonprofits.

3. ***All Deals:*** Lower the Hart-Scott-Rodino (HSR) threshold so FTC can examine smaller M&A deals (particularly vertical mergers between hospitals and physician groups)

4. ***Focus:*** Create and fund a fully staffed "Bureau of Health Care Competition" within the DOJ and FTC to specifically focus on competition issues.

5. ***Baseline for Mergers:*** Give FTC statutory authority to automatically presume hospital mergers are illegal (without requiring a case-by-case FTC analysis) unless certain thresholds are met.

6. ***State Medical Boards Role in Restraining Competition:*** Science and best practices in medicine do not change across artificial state borders, but medical board requirements do. A large body of academic research documents the consolidation of hospital markets and their effect on health care prices and quality. These studies find that such consolidation restrains competition in ways that directly affect prices without improving quality. Antitrust regulators have in the past undertaken studies of the practices of state medical boards, resulting in the courts restricting some of their anticompetitive practices. It is appropriate for regulators to conduct a fresh, thorough, and comprehensive analysis of the extent of state medical boards in restraining providers from entering and competing in the market and across state lines.

7. ***DOJ and FTC Should Systematically Review Local Markets:*** 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. FTC conduct and should publish an annual market-by-market HHI analysis and identify anti-competitive markets and make recommendations on breaking up existing monopolies such as by disapproving recent mergers, through upper payment limits, or other mechanisms.

8. ***Provider Licensing and Scope of Practice Rules:*** FTC and Department of Justice should issue a definitive review of CON state laws that drive up costs and provide definitive guidance on practices that limit provider competition.

C. Informed Consumers

Informed consumers are essential to the working of efficient markets. Research shows consumers with higher out-of-pocket costs are more likely to shop for coverage or switch doctors than those with lower costs. But consumers have less information on the price and quality of health care providers than they do on televisions or smart phones. Most providers do not provide prices publicly, and if they do, the prices typically reflect "charges"—list prices—that often exceed actual amounts collected by several fold. In addition, prices within local markets can vary by as much as 700 percent. For example, MRIs are largely a commodity, but their price varies greatly across geographic areas within zip codes.

Current regulations on price and quality disclosure should be enforced to ensure consumers have access to information already required by law. In addition, the Administration should take the following steps:

1. ***Gag Clauses:*** Hospitals often use "gag clauses" to prevent insurers from disclosing negotiated prices. DOJ should prohibit gag clauses as a standard in merger approvals. HHS should ensure hospitals disclose prices and quality measures by clarifying that refusal to share this information constitutes "information blocking" as defined in the 21st Century Cures act. HHS could do this by clarifying that disclosure is not an exception to information blocking under 45 CFR Part 171. Patients should be able to access data through an app of their choice via API that requires no special effort to access and retrieve the data.

2. ***Charitable Care:*** Information on charitable care policies is opaque at best, and hidden at worst. Hospitals should be required to disclose charitable care policies in an easy to find location and in clear terms on their website.

3. ***Competition in Enrollment:*** For too long HealthCare.gov and Medicare.gov have held monopoly status in information and/or enrollment in health plans. Health exchanges are a fundamentally sound idea. They reflect the proposition that informed consumers can stimulate system-wide improvements in the cost and quality of health care as they have in other realms. The exchanges are designed to facilitate online comparison shopping for health insurance plans by providing a transparent review of complicated price

and coverage details. CAHC has conducted an annual survey[10] to assess the e-commerce competency of the public exchanges created after the enactment of the ACA. The subjects of our study include the 15 exchanges run by individual states and the District of Columbia, as well as the federal health exchange, Healthcare.gov.

Our independent review offers an unbiased look at all of the exchanges — monopolies serving captive markets within their respective states. In some cases, state-run exchanges may be subject to chronically weak legislative oversight and the structural flaws inherent in monopolies are well-documented: Monopolies are notoriously insensitive to customer needs and can be laggards in innovation. Total reliance on public exchanges and enrollment efforts have proven to be insufficient to offer consumers 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 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.

D. Reforms that Benefit Low Income Working Americans

Health costs for working families have grown dramatically faster than pay, largely due to uncompetitive health markets. Rising premiums soak up raises that otherwise would boost living standards. Because costs (total, out-of-pocket, premiums, etc.) are rising faster than wages, health coverage is becoming less and less affordable. If current trends persist, the typical family will spend more than 40 percent of their income on premiums by 2032.

Behind the rise in health costs has been relentless inflation at the point of care. America spends about seventy percent more, as a share of GDP, on health care than the rich country average, yet has some of the lowest life expectancies across practically every socioeconomic group at practically every age. This unhealthiness stems in part from an epidemic of chronic diseases, including opioid abuse.

CAHC supports reforms that address these problems through reforms that benefit typical, working Americans, not big special interests.

1. ***End the moratorium on physician-owned hospitals:*** The ACA extended and intensive restrictions on physician-owned hospitals. Congress should repeal this *prima facie* restraint of competition.

2. ***Site-based payment disparities:*** Medicare and other federal programs often reimburse differentially for the same services based on site of care. This incentivizes provider consolidation and migration of services to high-cost hospital settings. The DOJ should work with Congress to require site-neutral payment across settings for the same service.

3. ***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 than lowering drug costs, the law increased them and limited price competition. Best price remains a

[10] Affordable Care Act (ACA) Exchange Report Card

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.

4. ***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.[11] 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. HHS should:

    - ***Define "Patient":*** Define an eligible patient in federal regulations that is consistent with program goals, namely, patients who are indigent and uninsured

    - ***End duplicate discounts:*** The 340B statute explicitly prohibits 340B hospitals from getting a 340B price for a medicine that also generates a Medicaid rebate. Establishing a 340B data information exchange to improve oversight and streamline claims and ensure that all claims are not paid duplicate rebates across federal and state programs would improve program integrity, trust in the program, better competition between 340B and non-340B entities, while lowering health costs.

    - ***Reduce Taxpayer Funded Arbitrage:*** Taxpayers should not fund covered entity mark ups on 340B drugs. Medicare should pay for 340B drugs based on acquisition costs.

5. ***Rewarding Healthy Behaviors:*** Providing rewards to people for engaging in healthy behaviors, meeting health goals, participating in preventive activities, promoting health literacy, and adhering to treatment regimens (particularly for those at risk of or who currently have a chronic condition) can improve outcomes and lower health costs. This should be encouraged. Employers have been increasing their investment in these programs for years, with 84 percent of employers offering wellness benefits in 2019.[12] While allowed in the group market, it is against the law, in most instances, for insurers to provide wellness incentives, such as rebates, for individuals who pay for their own health insurance in the individual market. This policy should be reversed, and states should set up programs to encourage healthy behavior and adherence to care plans and medications. Individual market insurers should have the ability to reward enrollees for engaging in healthy behavior and for managing their conditions with help from the plan and its network providers.

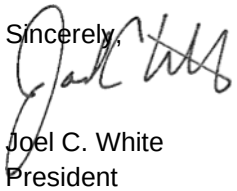
6. ***Let Consumers Vote With Their Feet:*** Consumers can only access tax subsidies and credits for insurance coverage through publicly run exchanges even though on- and off-exchange markets must have a unified risk pool for premium setting. This policy not only distorts the markets and limits consumer choice, but it also prevents innovative practices in the private sector from reaching many consumers. Consumers should have more and better options. 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 competition for consumer needs. 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.

Conclusion

[11] 340b-program-fact-sheet.pdf
[12] Trends in Workplace Wellness Programs and Evolving Federal Standards | KFF

The lack of meaningful competition in US health care markets is a function not just of market behavior, but of regulatory design. The DOJ's Anticompetitive Regulations Task Force offers a critical opportunity to rethink outdated frameworks that encourage consolidation, discourage innovation, suppress consumer choice, and increase costs. We commend your leadership, stand ready to support your efforts through continued dialogue and data-driven input, and welcome the opportunity to work with the Task Force to help identify solutions that will make health care more affordable for all Americans.

Sincerely,



Joel C. White
President