

“The Patient Protection and Affordable Care Act, Consolidation, and the Consequent
Impact on Competition in Healthcare”

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I. Introduction

Thank you Mr. Chairman and members of the committee. It is an honor to testify before you on a topic that is extraordinarily important to our nation's long-term fiscal health.

Latest statistics reveal that the United States spends nearly 18% of its Gross Domestic Product on health care services. This is nearly twice the average for OECD nations and far more than #2, which spends less than 12%. Viewed another way, the United States in purchase-adjusted dollars spends more than two-and-a-half times the OECD average per capita on health care and more than one-and-a-half times the second largest spender. Yet in spite of our leadership in healthcare spending, we are safely in the bottom half of OECD nations on most measures of health care outcomes.

We are spending too much and getting too little in return, and the nation simply is on an unsustainable trajectory. All discussions about healthcare policy should begin with the recognition that curbing healthcare spending needs to be among our highest national priorities. The cost of private health insurance is bankrupting companies and families alike, and the cost of public healthcare programs are putting unmanageable burdens on the federal and state budgets.

Many studies suggest that the cost of healthcare is unsustainable not because we consume too much healthcare, but because we pay too much for the healthcare that we do consume. In other words, as one study put it famously, "It's the Prices,

Stupid.”¹ And one of the most severe contributors to the rise of health care prices has been the alarming rise in market power by healthcare providers.

The past several decades have witnessed extraordinary consolidation in local hospital markets, with a particularly aggressive merger wave occurring in the 1990s. By 1995, merger and acquisition activity was nine times its level at the start of the decade, and by 2003, almost ninety percent of Americans living in the nation’s larger MSAs faced highly concentrated markets.² This wave of hospital consolidation alone was responsible for sharp price increases, including price increases of 40% when merging hospitals were closely located.³ Even after this merger wave in the 1990s prompted alarm, a second merger wave from 2006 to 2009 significantly increased the hospital concentration in 30 MSAs, and the vast majority of Americans are now subject to monopoly power in their local hospital markets.⁴

¹ Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, HEALTH AFFS., May-June 2003, at 89.

² William B. Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson(2006); Claudia H. Williams, et. al., *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON FOUND., (2006), available at www.rwjf.org/files/research/no9policybrief.pdf

³ Id. For surveys of how hospital consolidations have increased hospital prices, see Gloria J. Bazzoli et al., *Hospital Reorganization and Restructuring Achieved Through Merger*, 27 HEALTH CARE MGMT. REV. 7 (2002); Martin Gaynor, *Competition and Quality in Health Care Markets*, 2 FOUNDATIONS & TRENDS IN MICROECONOMICS 441 (2006); see also William B. Vogt, *Hospital Market Consolidation: Trends and Consequences* (2006), NAT’L INST. FOR HEALTH CARE MGMT., available at http://nihcm.org/pdf/EV-Vogt_FINAL.pdf (documenting the extent of provider market concentration among hospitals & other providers).

⁴ Cory Capps & David Dranove, *Market Concentration of Hospitals* (June 2011), available at: <http://www.ahipcoverage.com/wp-content/uploads/2011/10/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf>

Hospitals and hospital networks did not achieve this market dominance through “superior skill, foresight, and industry,”⁵ which would be unobjectionable under the antitrust laws. To the contrary, this consolidation occurred because of mergers and acquisitions, and permitting hospital markets to achieve such remarkable levels of consolidation represents a major failure of our antitrust policy. There is plenty of blame to share—both Democratic and Republican Administrations; Congress, the Executive, and the Courts—but we are now in a position where we must cope with hospital monopolists. In other words, we not only must resist any additional consolidation that creates greater market power, but we must develop policy tools that stem the harm that current hospital monopolists are in a position to inflict.

My testimony is divided into three parts. The first briefly reviews some of the failures of antitrust policy that permitted hospital consolidations, with a focus on court decisions in the 1990s. The second part explains why hospital and healthcare provider monopoly power is especially costly, even more costly to American consumers than what one might call a “typical” monopolist. The third part, discusses available policy instruments to protect healthcare consumers against current and growing hospital monopolists. Of particular interest is monitoring the unfurling of Accountable Care Organizations (“ACOs”), which are encouraged by the Patient Protection and Affordable Care Act (“ACA”) and, though aiming to address important failures in coordinating care, pose a serious danger to creating additional provider market power.

⁵ *United States v. Aluminum Co. of America*, 148 F.2d 416, 430 (2d Cir. 1945) (Hand, J.) (“The successful competitor, having been urged to compete, must not be turned upon when he wins.”)

II. Explaining Past Failures in Antitrust Policy

Ever since the antitrust laws were first applied systematically in the health care sector in the mid-1970s, some judges and commentators have resisted giving the statutory policy of fostering competition its due effect in health care settings.⁶ Between 1995 and 2000, for example, antitrust enforcers encountered judicial resistance when challenging mergers of nonprofit hospitals, suffering a six-case losing streak in such cases in the federal courts.⁷ Although most of those pro-merger decisions ostensibly turned on findings of fact (mostly in identifying a geographic market in which to estimate the merger's probable effects on

⁶ For cases in which the Supreme Court found it necessary to overrule lower courts' attempts to infer special antitrust exemptions or craft softer antitrust rules for health care providers, see *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378 (1981) (rejecting implied exemption for market-allocation agreements brokered by health planning agencies created under federal statute); *Patrick v. Burget*, 486 U.S. 94 (1988) (rejecting state legislature's encouragement of physician peer review in hospitals as a basis for exempting abuses from federal antitrust remedies); *Summit Health v. Pinhas*, 500 U.S. 322 (1991) (easing standard for establishing potential effect of hospital medical staff decisions on interstate commerce); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982) (treating physicians' collective agreements on maximum prices as unlawful because claim of procompetitive effects was facially unconvincing); *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986) (upholding adequacy of evidence to support FTC finding that dentists' agreement to deny insurers access to patients' x-rays was anticompetitive, not procompetitive). But see *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999) (raising FTC's burden of proof in finding anticompetitive collective action by health professionals). The latter decision is critically examined in Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL. POL'Y & L. 939, 949-53 (2001). The antitrust movement in health care was triggered in part by the Supreme Court's rejection in 1975 of general antitrust immunity for the so-called "learned professions." *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). See generally CARL F. AMERINGER, *THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION* (2008).

⁷ U.S. FED. TRADE COMM'N AND U.S. DEPT. OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* ch. 4, at 1-2 n. 7 (2004), available at http://www.usdoj.gov/atr/public/health_care/204694.htm (accessed 13 May 2009) [hereinafter DOSE OF COMPETITION].

competition), those findings were often so arbitrary as to signify judicial skepticism about the wisdom of applying antitrust law rigorously in hospital markets.⁸ Even as nonprofit hospitals became the primary provider of the nation's hospital care—responsible for 73% of admissions, 76% of outpatient visits, and 75% of hospital expenditures—they tended to enjoy selective scrutiny under the antitrust laws. Implicitly, and often explicitly, the judges seemed to harbor a belief that nonprofit hospitals either would not exercise or would put to good use any market power they might possess.⁹

The courts' inability over time to apply antitrust law rigorously to the big business of health care—and the FTC's failure in convincing them to do so, and

⁸ For discussions of these cases and of the general ambivalence towards competition in health care markets, see Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007); Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gasses? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497 (2006); Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191 (1997).

⁹ The district judge in *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), was especially unambiguous in championing nonprofit hospitals as benign monopolists:

Permitting defendant hospitals to achieve the efficiencies of scale that would clearly result from the proposed merger would enable the board of directors of the combined entity to continue the quest for establishment of world-class health facilities in West Michigan, a course the Court finds clearly and unequivocally would ultimately be in the best interests of the consuming public as a whole.

Id. at 1302. Likewise, the judge revealed a hostility to price competition between hospitals, remarking that “[i]n the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars.” *Id.* The *Butterworth* court was not alone in its predilections. A Missouri judge, reviewing a hospital merger challenged by the FTC, remarked to the federal agency, “I don’t think you’ve got any business being in here. . . . It looks to me like Washington, D.C. once again thinks they know better what’s going on in southwest Missouri. I think they ought to stay in D.C.” *FTC v. Freeman Hosp.*, 69 F.3d 260, 263 (8th Cir. 1995) (quoting district court oral hearing).

Congress' failure in instructing them to do so—is one important reason why many health care markets are now dominated by firms with alarming pricing power.¹⁰ Fortunately, the government has more recently won back some of the legal ground it lost.

A. Dispelling the Myth that Nonprofit Hospitals Do Not Exercise Pricing Power

In 2007, the Federal Trade Commission (FTC), in a case challenging a merger of nonprofit hospitals on Chicago's North Shore, found convincing proof that, following the merger, the new entity had substantially raised prices to managed-care organizations.¹¹ The case was unusual because, rather than intervening to stop the acquisition when it was first proposed, the Commission initiated its challenge four years after the merger was consummated. Bringing the case at that stage accomplished two things: First, it made it unnecessary for the Commission to seek a preliminary injunction against the merger in federal court – where antitrust enforcers had lost the six previous cases. Second, challenging a completed merger gave the Commission's staff an opportunity to demonstrate in fact, and not just in theory, that nonprofit hospitals gaining new market power will use it to increase

¹⁰ For surveys of how hospital consolidations have increased hospital prices, see G.B. Bazzoli, et al., "Hospital Reorganization and Restructuring Achieved through Merger," 27 HEALTH CARE MANAGEMENT REV. 7 (2002); Martin Gaynor, *Competition and Quality in Health Care Markets*, 2 FOUNDATIONS AND TRENDS IN MICROECONOMICS 441 (2006); William B. Vogt, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, THE SYNTHESIS PROJECT, at 9 (2006). See also See William B. Vogt, Hospital Market Consolidation: Trends and Consequences, EXPERT VOICES, NIHCM Foundation, available at: http://nihcm.org/pdf/EV-Vogt_FINAL.pdf (documenting the extent of provider market concentration among hospitals & other providers).

¹¹ In re Evanston Northwestern Healthcare Corp., 2007 WL 2286195 (F.T.C. 2007).

prices. The direct proof obtained in the *Evanston Northwestern* case makes it unlikely that future federal courts will allow the consummation of mergers of nonprofit hospitals under the illusion that such mergers do not have the usual anti-competitive effects.

The FTC's findings in *Evanston Northwestern* also discredited expert economic testimony that one court had cited prominently in approving a hospital merger in Grand Rapids, Michigan. That testimony rested on empirical research purporting to show that in concentrated markets nonprofit hospitals generally had lower prices than corresponding for-profits.¹² Although that research had been effectively discredited in later economic studies,¹³ the facts found in *Evanston Northwestern* should put finally to rest the notion that nonprofit hospitals are immune from the temptation to raise prices when they are in a position to do so.

Evanston Northwestern's findings also undercut the common belief that community leaders on a nonprofit hospital's governing board are vigilant about health care costs. The judge in the Grand Rapids case permitted the merger in part because the chairmen of the two hospitals' boards each represented a large local

¹² *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1297 (W.D. Mich. 1996) (citing expert's findings suggesting "that a substantial increase in market concentration among nonprofit hospitals is not likely to result in price increases"). The expert cited by the court, William J. Lynk, reached the same conclusion in scholarly articles. William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437 (1995); William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363, 377 (1994).

¹³ See DOSE OF COMPETITION, *supra* note 7, ch.4, at 33 (concluding "the best available evidence indicates that nonprofits exploit market power when given the opportunity to do so"); David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87 (1999); Emmett B. Keeler, Glenn Melnick, & Jack Zwanziger, *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69 (1999).

employer and “testified convincingly that the proposed merger [was] motivated by a common desire to lower health care costs”¹⁴ In this same vein, a proponent of another hospital merger not long ago gave assurance that allowing it would not cause health insurance premiums to increase because several hospital “board members . . . are employers who worry about the cost of health-care.”¹⁵ Economists generally agree, however, that employees themselves, not employers, ultimately bear the cost of their own health coverage in reduced wages or other fringe benefits.¹⁶ To be sure, employers are never happy to pay higher insurance premiums and would prefer to increase their employees’ compensation in more visible ways. But they are ultimately committing their workers’ money, not their own (or their shareholders’), in hospital boardrooms. Moreover, nonprofit hospitals have few legal or institutional reasons to engage in only progressive redistribution.¹⁷ In general, community leaders on nonprofit hospital boards have little incentive to resist any hospital project that seems good for the community if it can be financed from the hospital’s reserves and future surpluses.

¹⁴ 946 F. Supp. at 1297.

¹⁵ Felice J. Freyer, *Hospital Merger Reaction Cautious*, PROVIDENCE JOURNAL-BULLETIN, July 29, 2007, at B1 (describing proposed merger of Rhode Island’s two largest hospital systems). See also *FTC v. Freeman Hospital*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995) (“if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level, even if it has the power to do so”)

¹⁶ See generally Jonathan Gruber, *Health Insurance and the Labor Market* (Nat’l Bureau of Econ. Research, Working Paper No. 6762, 1998) (reviewing the empirical literature and finding “a fairly uniform result: the costs of health insurance are fully shifted to wages”).

¹⁷ See Timothy Greaney & Kathleen Boozang, *Mission, Market and Trust in the Nonprofit Healthcare Enterprise*, 5 YALE J. HEALTH LAW & POL. 1 (2005); Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 22-24.

A recent report by the Massachusetts Attorney General documents how nonprofit hospitals in that state have aggressively exploited their market power, even when health care costs were strangling public and private budgets.¹⁸ Following Massachusetts's passage of the nation's first legislative effort to achieve universal health coverage, the state legislature directed the Attorney General to analyze the causes of rising health care costs. The resulting report concluded that prices for health services are uncorrelated with either quality or costs of care but instead are positively correlated with provider market power.¹⁹ The report further observed that prominent nonprofit academic medical centers—specifically, the Massachusetts General Hospital and Brigham and Women's Hospital, which had merged in 1993 to create Partners HealthCare—were most responsible for leveraging their market and reputational power to extract high prices from insurers.²⁰ Reporting by the *Boston Globe* had previously shown the surprising extent to which Partners was able to extract extraordinary prices in agreements with presumably cost-conscious insurers.²¹ For example, when some insurers, such as the Tufts Health Plan, resisted Partners' demands for price increases and tried to assemble networks with Boston's other hospitals, Partners launched an aggressive

¹⁸ Massachusetts Attorney General, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b)* (March 16, 2010), available at: http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf [hereinafter "Health Care Cost Trends"]

¹⁹ *Id.* at 16-33.

²⁰ *Id.*; see especially 29-30.

²¹ Special Report: Unhealthy System, available at: http://www.boston.com/news/specials/healthcare_spotlight/ (detailing special reporting on Partners HealthCare, culminating in a three-part series); "A Healthcare System Badly Out of Balance," *Boston Globe*, Nov. 16, 2008; "Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs," *Boston Globe*, Dec. 21, 2008; "A Handshake That Made Healthcare History," *Boston Globe*, Dec.28, 2008.

marketing campaign that triggered threats by many of Tufts' corporate customers to switch insurers.²²

The foregoing observations should finally dispel any impression that nonprofit hospitals, as community institutions, can safely be allowed to possess market power on the theory that, as nonprofits, they can be trusted not to exercise it.

B. Dispelling the Myth that Nonprofit Hospitals Use Profits for Charitable Purposes

Federal judges may have tolerated mergers conferring new market power on nonprofit hospitals less because they thought the hospitals would not exercise that power than because such hospitals seemed to differ from conventional monopolists in ways that should lessen social concern about their enrichment. Specifically, nonprofit, tax-exempt hospitals are required by their charters and the federal tax code to retain their profits and use them only for "charitable" purposes. Thus, if one could assume that the redistributions of wealth resulting from the exercise of market power by nonprofit hospitals run generally from richer to poorer rather than in the opposite direction, there would be at least an argument for viewing nonprofit hospital monopolies as benign for antitrust purposes. Although such an argument would be based on a questionable reading of the antitrust statutes, one

²² "A Handshake That Made Healthcare History," *id.*, (describing the "humiliation" experienced by the Tufts Health Plan's CEO as he caved to Partners' price demands and "became an object lesson for other insurers, a lesson they would not soon forget [as the] the balance of power had shifted" to Partners). In Orlando, insurer United Healthcare experienced similar threats as it resisted a request for a 63 percent price increase by the region's leading nonprofit hospital chain. Linda Shrieves, *400,000 Fear They'll Have to Switch Doctors*, ORLANDO SENTINEL, Aug.7, 2010.

widely noted case allowed prestigious universities to act anti-competitively in order to direct their limited scholarship funds toward lower-income students.²³ One easily senses in hospital merger cases a similar judicial dispensation in favor of nonprofit enterprises that combine for seemingly progressive purposes.²⁴

But however antitrust doctrine views (or should view) monopolies dedicated to progressive pursuits, it is far from clear that nonprofit hospitals reliably use their dominant market positions to redistribute wealth only in progressive directions. The Internal Revenue Code's charitable-purposes requirement has been interpreted very broadly, allowing such hospitals to spend their untaxed surpluses on anything that arguably "promotes health."²⁵ This includes much more than just caring for the indigent. Indeed, many exempt hospitals are located in areas that need relatively little in the way of truly charitable care, either because the community is relatively affluent and its population well-insured or because a public hospital assumes most of the charity burden. Moreover, although all hospitals inevitably subsidize the treatment of some uninsured patients, many of today's uninsured are members of the middle class and not obvious candidates for subsidies from the insured

²³ *United States v. Brown Univ.*, 5 F.3d 658 (3d Cir. 1993). Reading this ruling as an endorsement of the universities' redirection of scholarship funds to needier students would at least limit substantially (and prudently) the kind of worthy purpose a cartel of nonprofit entities may offer as an antitrust defense.

²⁴ *See, e.g., supra* note 9.

²⁵ Rev. Rul. 69-545, 1969-2 C.B. 117 (1969). Ironically, this controversial ruling, relaxing an earlier requirement that an exempt hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered," Rev. Rul. 56-185, 1956-1 C.B. 202, came at a time when the Medicare and Medicaid programs were relatively new and private health insurance was expanding, all seemingly reducing the need for nonprofit hospitals to be charitable in the original sense.

population.²⁶ Finally, federal, state, and local governments separately and substantially subsidize nonprofit hospitals' most clearly charitable activities, both through special tax exemptions and relief and by direct subventions; such activities therefore should not count significantly in estimating the net direction of redistributions effected by hospitals through the exercise of newly acquired market power.

Thus, true charity has in recent years accounted for only a relatively small fraction of what nonprofit hospitals do in return for their federal tax exemptions. Indeed, such hospitals can usually qualify for exemption merely by spending their surpluses on medical research, on training various types of health care personnel, and, most importantly, on acquiring state-of-the-art facilities and equipment, which (ironically) can also secure and enhance their market dominance.²⁷ Many of these

²⁶ Supplemental census data from 2007 showed that nearly 38% of America's uninsured come from households with over \$50,000 in annual income and nearly 20% from households with over \$75,000. See U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES 21 table 6 (August 2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>. Implementation of the PPACA will greatly reduce hospitals' charity burdens, leaving illegal aliens as the principal category of the uninsured.

²⁷ On Partners HealthCare's use of its surpluses to build new and better facilities and expand into new markets, thereby securing additional market power, see "Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs," BOS. GLOBE, Dec. 21, 2008.

Not only does tax exemption create opportunities for dominant firms to increase their dominance, but a nonprofit firm lacking such dominance may be ineligible for exemption – and thus at a severe competitive disadvantage – precisely because it faces competition and therefore lacks the discretionary funds necessary to demonstrate how it “benefits the community.” Tax policy thus rewards, fosters, and protects provider monopoly, only ensuring that monopoly profits, however large, are not put to objectionable, non-health-related uses. *Cf. Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993) (denying tax exemption to nonprofit health plan in part because it was not a provider, but only arranged for the provision, of health services and also because, although it planned to subsidize

activities confer significant benefits on interests and individuals relatively high on the income scale.²⁸ To be sure, most of the activities and projects financed from hospital surpluses are hard to criticize in the abstract. But many of them are not so obviously progressive in their redistributive effects (or otherwise so obviously worthy of public support) that antitrust prohibitions should be relaxed so that hospitals can finance more of them.

In any case, financing hospital activities and projects of any kind from hospitals' monopoly profits causes their costs to fall ultimately and more or less equally on individuals bearing the cost of health insurance premiums. The incidence of this financial burden thus closely resembles that of a "head tax" – that is, one levied equally on individuals regardless of their income or ability to pay. Few methods of public finance are more unfair (regressive) than this. Those who take a benign view of the seemingly good works of health care providers should focus more attention on who (ultimately) pays for and who benefits from those nominally charitable activities.²⁹

premiums for some low-income subscribers, it had been "unable to support the program with operating funds because it operated at a loss from its inception").

²⁸ Many physicians, for example, benefit handsomely first from the valuable training hospitals provide and later from using expensive hospital facilities and equipment at no direct cost to themselves. The tax authorities regard such "private benefits" as merely "incidental" to the hospitals' larger purpose of promoting the health of the community. See I.R.S. Gen. Couns. Mem. 39,862 (Dec. 2, 1991): "In our view, some private benefit is present in all typical hospital-physician relationships. . . . Though the private benefit is compounded in the case of certain specialists, such as heart transplant surgeons, who depend heavily on highly specialized hospital facilities, that fact alone will not make the private benefit more than incidental."

²⁹ See generally Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, LAW & CONTEMP. PROBS., Autumn 2006.

The regressive redistributive effects of nonprofit hospitals' monopolies appear never to have been given due weight in antitrust appraisals of hospital mergers.³⁰ To be sure, pure economic theory withholds judgment on the rightness or wrongness of redistributing income because economists have no objective basis for preferring one distribution of wealth over another. But the antitrust laws enjoy general political support principally because the consuming public resents the idea of illegitimate monopolists enriching themselves at their expense.³¹ This is why mergers of all kinds are suspect in the eyes of antitrust enforcers: they may be an easy and unjustified shortcut to gaining market power. Although proponents of consolidations increasing concentration in provider markets usually tout efficiencies they expect to achieve by combining and rationalizing operations, the opportunity to increase their bargaining power vis-à-vis private payers is the likelier explanation for all such mergers in concentrated markets.³²

³⁰ Under reasonable assumptions, a hospital merger creating new market power would raise insurance premiums by roughly 3 percent, increasing the "head tax" on the median insured family by roughly \$400 per year, hardly a trivial amount. In addition, according to one estimate, hospital mergers in the 1990s caused nearly 700,000 Americans to lose their private health insurance. Robert Town et al., *The Welfare Consequences of Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 12244, 2006).

³¹ HERBERT HOVENKAMP, *FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE* 50 (3d ed. 2005) ("[T]he primary intent of the Sherman Act framers [was] the distributive goal of preventing monopolists from transferring wealth away from consumers.")

³² See DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE* 122 (2000): "I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power." See also Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 *HEALTH AFF.* 699, 699 (2010), at 6 (quoting a local physician as saying, "Why are those hospitals and physicians [integrating]? It wasn't for increased coordination of

In sum, a tragic failure of antitrust enforcement—fueled in no small part by certain sanguine attitudes toward nonprofit monopolies—contributed to what is now a crisis in provider markets. As a result, there are few markets in which price competition keeps prices for specific hospital and other health care services and goods near their marginal cost. The ubiquity of nonprofit hospitals with market power now constitutes a significant source of the provider-monopoly problem in health care.

III. The Particular Costliness of Healthcare Provider Monopolies: Market Power + Insurance

In economic theory, monopoly is objectionable because it enables a seller to charge higher prices that then cause some consumers, who would happily pay the competitive price, to forgo enjoyment of the monopolized good or service. Monopolists thus divert scarce resources to less-valued uses and reduce aggregate welfare. Fortunately, such output- and welfare-reducing (misallocative) effects are greatly lessened in health care markets because the large number of patients with health insurance can easily pay provider monopolists' asking prices for desirable goods or services rather than being induced to forgo their consumption. Unfortunately, however, health insurance has other, possibly more severe consequences because it both amplifies the redistributive effects of provider and supplier monopolies and contributes to allocative inefficiency of a different and arguably more serious kind.

care, disease management, blah, blah, blah – that was not the primary reason. The wanted more money and market share.”)

A. Supra-Monopoly Pricing

In the textbook model, monopoly redistributes wealth from consumers to powerful firms. The monopolist's higher price enables it to capture for itself much of the welfare gain, or "surplus," that consumers would have enjoyed if they had been able to purchase the valued good or service at a low, competitive price. In health care, insurance puts the monopolist in an even stronger position by greatly weakening the constraint on its pricing freedom ordinarily imposed by the limits of consumers' willingness or ability to pay. This effect appears in theory as a steepening of the demand curve for the monopolized good or service. Whereas most monopolists encounter a reduction in demand with each price increase, health insurance mutes the marginal consequences of rising prices.

If health insurers were dutiful agents of their subscribers and perfectly reflected subscribers' preferences, they would reflect consumers' demand curve and pay only for services that were valued by individual insureds at levels higher than the monopoly price. Deficiencies in the design and administration of real-world health insurance, however, prevent insurers from reproducing their insureds' preferences and heavily magnify monopoly power. For legal, regulatory, and other reasons, health insurers in the United States are in no position (as consumers themselves would be) to refuse to pay a provider's high price whenever it appears to exceed the service's likely value to the patient. Instead, insurers are bound by both deep-rooted convention and their contracts with subscribers to pay for any service that is deemed advantageous (and termed "medically necessary" under

rather generous legal standards) for the patient's health, whatever that service may cost.³³

Consequently, close substitutes for a provider's services do not check its market power as they ordinarily would for other goods and services. Indeed, putting aside the modest effects of cost sharing on patients' choices, the only substitute treatments or services that insured patients are likely to accept are those they regard as the best ones available. Unlike the situation when an ordinary monopolist sells directly to cost-conscious consumers, the rewards to a monopolist selling goods or services purchased through health insurance may easily and substantially exceed the aggregate consumer surplus that patients would derive at competitive prices.

Thus, health insurance enables a monopolist of a covered service to charge substantially more than the textbook "monopoly price," thereby earning even more than the usual "monopoly profit." The magnitude of the monopoly-plus-insurance distortion has sometimes even surprised its beneficiaries.³⁴ Of course, since third-party payors (and not patients) are covering the interim bill, these extraordinary profits made possible by health insurance are earned at the expense of those

³³ See generally Timothy P. Blanchard, "Medical Necessity" Determinations—A Continuing Healthcare Policy Problem," *Journal of Health Law* 37, no. 4 (2003): 599–627; William Sage, "Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance," *Duke Law Journal* 53 (2003): 597; Einer Elhauge, "The Limited Regulatory Potential of Medical Technology Assessment," *Virginia Law Review* 82 (1996):1525–1617.

³⁴ For truly stunning examples of the price-increasing and profit-generating effects of combining US-style health insurance and monopoly, see Geeta Anand, "The Most Expensive Drugs," Parts 1–4, *Wall Street Journal*, November 15–16, December 1, 28, 2005; in this series, see especially "How Drugs for Rare Diseases Became Lifeline for Companies," November 15, 2005, A1 (in which one drug company executive is quoted as saying, "I never dreamed we could charge that much.")

bearing the cost of insurance. Insureds, even when their employers are the direct purchasers of health insurance, are ultimately the ones seeing their take-home shrink from hikes in insurance premiums caused by provider monopolies.

Discussions of antitrust issues in the health care sector rarely, if ever, explicitly observe how health insurance in general or U.S.-style insurance in particular enhances the ability of dominant sellers to exploit consumers. Although scholars have previously observed that prices for health services are much higher in the United States compared to other OECD nations (without observable differences in quality),³⁵ and although many have observed that provider market power has been a significant factor in inflating those prices,³⁶ few have observed the synergistic effects of monopoly and health insurance.

Perhaps more notably, despite the huge implications for consumers and the general welfare, the special redistributive effects of monopoly in health care markets are not mentioned in the antitrust agencies' definitive statements of enforcement policy in the health care sector.³⁷ Antitrust analysis of hospital mergers—as well as of other actions and practices that enhance provider or supplier market power—must therefore explicitly recognize the impact of insurance on health care markets. The nation will find it far harder, perhaps literally impossible, to afford PPACA's impending extension of generous health coverage to additional millions of consumers if monopolists of health care services and products can continue to charge not what “the market” but what insurers will bear.

³⁵ See, e.g., Diana Farrell et al., *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, (McKinsey Global Institute, 2008).

³⁶ See *supra*, notes 2-3.

³⁷ See *supra*, note 7.

B. Misallocative Consequences

Allowing providers to gain market power by merger not only causes extraordinary redistributions of wealth but also contributes to inefficiency in the allocation of resources. In ironic contrast to the output restrictions associated with monopoly in economic theory, the misallocative effects cited here mostly involve the production and consumption of too much—rather than too little—of a generally good thing. These misallocations are both theoretically and practically important. They provide still another new reason for special antitrust and other vigilance against providers' monopolistic practices, particularly scrutinizing anticompetitive mergers and powerful joint ventures.

Even in the absence of monopoly, conventional health insurance enables consumers and providers to overspend on overly costly health care. This is, of course, the familiar effect of moral hazard—economists' term for the tendency of patients and providers to spend insurers' money more freely than they would spend the patient's own. To be sure, some moral-hazard costs are justified as an unavoidable price to protect individuals against unpredictable, high-cost events. But American health insurers are significantly constrained in introducing contractual, administrative, and other measures to contain such costs. U.S.-style health insurance is therefore more destructive of allocative efficiency than health insurance has to be. Although uncontrolled moral hazard is a problem throughout the health sector, combining inefficiently designed insurance with provider monopolies compounds the economic harm.

The extraordinary profitability of health-sector monopolies also introduces a dynamic source of resource misallocation by greatly strengthening the usual inducement for firms to seek market dominance. The introductions of new technologies have been a major source—perhaps primary, responsible for as much as 40-50 percent—of healthcare cost increases over the past several decades.³⁸ And even though many innovations offer only marginal value, their monopoly power under intellectual property laws secure lucrative payments from insurers whose hands are tied. Although many have recognized that new technologies are a principal source of unsustainable increases in health care costs, and several others have recognized how the moral hazard of insurance has both fueled technology-driven cost increases and distorted innovation incentives (toward cost-increasing innovations at the expense of cost-reducing innovations),³⁹ few have appreciated the contributing role of insurance in exacerbating the monopolies' effects.

³⁸ Daniel Callahan, "Health Care Costs and Medical Technology," in *From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns*, ed. Mary Crowley (Garrison, NY: The Hastings Center, 2008), 79–82. See also Paul Ginsburg, "Controlling Health Care Costs," *New England Journal of Medicine* 351 (2004): 1591–93; Henry Aaron, *Serious & Unstable Condition* (Washington, DC: Brookings Institution Press, 1991).

³⁹ See Alan M. Garber, Charles I. Jones, and Paul M. Romer, "Insurance and Incentives for Medical Innovation" (working paper 12080, National Bureau of Economic Research, 2006); Burton Weisbrod, "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature* 29, no. 2 (June 1991): 523–52; Sheilah Smith, Joseph P. Newhouse, & Mark Freeland, "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs* 28, no. 5 (2009): 1276–84. See also Dana Goldman and Darius Lakdawalla, "Understanding Health Disparities across Education Groups" (working paper 8328, National Bureau of Economic Research, 2001) (suggesting that population-wide increases in education have encouraged pursuit of patient-intensive innovations that increase costs, rather than simpler technologies that reduce them).

Provider monopolies also inflict economic harm by spending heavily to sustain current monopoly barriers. Indeed, Richard Posner has theorized that monopoly's most serious misallocative effect is not the output reduction recognized in theoretical models but instead is the monopolist's strenuous efforts to obtain, defend, and extend market power.⁴⁰ A monopolist is willing to invest up to the private value of its monopoly in maintaining it (and keeping out competitors), and the more lucrative the monopoly, the more a firm will be induced to invest heavily in sustaining monopoly barriers. Since so many monopolies are maintained with legal and regulatory barriers—certificate-of-need laws, accreditation, and contracts restricting provider networks, for example—much of this effort is spent on legal and political resources that fritter away the private value of the monopoly, rather than reinvesting in activities that create additional social value. Even managers of nonprofit firms, though they have no interest in profits as such, have incentives to maintain monopolies to fund the construction and expansion of empires that enhance their self-esteem and professional influence. Such empire building is most easily accomplished by obtaining market power and using it to generate surpluses with which to further entrench and extend the firm's dominance.

In light of the disproportionately large share of national resources already being spent on health care in the United States compared to every other nation in the world, and especially once one recognizes the extraordinary pricing freedom that U.S.-style health insurance confers on monopolist providers and suppliers, the enormous burden of distortive health-sector monopolies provide compelling, even

⁴⁰ Richard A. Posner, *Antitrust Law: An Economic Perspective*, 2nd ed. (University of Chicago Press, 2001), 13–18.

alarming, reasons to apply the antitrust laws with particular force. Antitrust policymakers, I believe, are up to the task of restoring competition in healthcare markets where it is lacking, but it will require targeting providers and suppliers of health services seeking to achieve, entrench, and enhance market power.

IV. A New Antitrust Agenda

Can government, through antitrust enforcement or otherwise, do anything about the problem of provider and supplier market power in health care markets?

Although the enforcement agencies and courts should certainly scrutinize new hospital mergers and similar consolidations with greater skepticism, preventing new mergers cannot correct past failures to maintain competition in hospital and other markets. Enforcers may challenge the legality of previously consummated mergers, as the FTC did in the Evanston Northwestern case, but there are practical and judicial difficulties in fashioning a remedy that might restore the competition that the original merger destroyed. The FTC was unwilling, for example, to demand the dissolution of Evanston Northwestern Healthcare Corp. and instead merely ordered its jointly operated hospitals to negotiate separate contracts with health plans—a remedy, incidentally, that gave the negotiating team of neither hospital any reason to attract business from the other.⁴¹ Although the FTC might seek more substantial relief in other such cases, the general rule seems to be that old, unlawful

⁴¹ Despite losing thoroughly on the merits, the respondent declared itself “thrilled” with the FTC’s remedy. See North Shore University Health Systems “FTC Ruling Keeps Evanston Northwestern Healthcare Intact,” press release, August 6, 2007, www.northshore.org/about-us/press/pressreleases/ftc-ruling-keeps-evanston-northwestern-healthcareintact/ (accessed May 3, 2012).

mergers are amenable to later breakup only in the unusual case where the component parts have not been significantly integrated.⁴² In any case, given their past skepticism about antitrust enforcement in health care markets, and especially their hand in blessing many mergers that ought now be unwound, courts would be hard to enlist in an antitrust campaign to roll back earlier consolidations.⁴³

Thus, a policy agenda capable of redressing the provider monopoly problem in health care will need to employ other legal and regulatory instruments. A first order of business would be to fastidiously prevent the formation of new provider monopolies. Because healthcare providers continue to seek opportunities to consolidate—either through the recent wave of forming Accountable Care Organizations (“ACOs”) or through alternative means—there remain several fronts available for policymakers to wage antitrust battle. In addition, an array of other enforcement policies can target monopolists behaving badly—those trying either to expand their monopoly power into currently competitive markets or to foreclose their market to possible entrants. Thus, several fronts remain available for policymakers seeking to restore competition to healthcare markets. A new antitrust agenda begins with recognizing the extraordinary costs to healthcare provider monopolies and continues with aggressive and creative antimonopoly interventions.

⁴² See, for example, *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586 (1957); see also Phillip Areeda and Herbert Hovenkamp, *Antitrust Law* 2nd ed. (New York: Aspen Publishers, 2003): 1205b.

⁴³ For a chronicling of government challenges to mergers that lost in federal court, see *Dose of Competition*, *supra* note 7. For an exploration of judicial resistance to enforcing the antitrust laws against hospitals, see Richman, *supra* note 8.

A. The Special Problem of Accountable Care Organizations

A primary target for a revived antitrust agenda is the emerging Accountable Care Organizations, whose development the Affordable Care Act is designed to stimulate. The ACA encourages providers to integrate themselves in ACOs for the purpose of implementing “best practices” and thereby providing coordinated care of good quality at low cost. As an inducement for providers to form and practice within these presumptively more efficient entities, the ACA instructs the Medicare program to share with an ACO any cost savings it can demonstrate, permitting proposed ACOs either to keep any savings beyond a minimum savings rate (“MSR”) of up to 3.9% while being insured against losses if savings are not obtained or to keep savings beyond an MSR of 2% while being exposed to the risk of losses.⁴⁴ ACOs are being hailed as a meaningful opportunity to reform our deeply inefficient delivery system, but the unintended consequences of promising health policy initiatives often invest prematurely in projects that ultimately disappoint. The formation of ACOs run the specific risk of creating even more aggregation of pricing power in the hands of providers.

ACOs, in theory, could offer an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery system.⁴⁵ Together with good information systems and compensation arrangements, vertical integration of complementary health care entities can achieve important efficiencies

⁴⁴ See Department of Health and Human Services, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 CFR Part 425, Federal Register 76, no. 212 (November 2, 2011): 67802, 67985–88.

⁴⁵ Einer Elhauge, ed., *The Fragmentation of US Health Care* (Oxford, UK: Oxford University Press, 2010).

by reducing medical errors, obviating duplicative services and facilities, and coordinating elements needed to deliver high quality, patient-centered care.⁴⁶

Skeptics, who include former FTC Commissioner Thomas Rosch, note that “available evidence suggests that the cost savings [from ACOs] will be very small to nonexistent” and warn that any purported reductions in expenditures “will simply be shifted to payors in the commercial sector.”⁴⁷ Others have warned that efforts to replicate early successes in integrated delivery systems—which serve as models for reformers’ aspirations—have often failed, in part because many physicians are reluctant to forgo the lucrative possibilities of unconstrained fee-for-service practice and in part because physicians who do integrate with hospital systems predictably resist adhering to efficiency-enhancing management. Moreover, many ACOs are reportedly being sponsored by hospitals, which any efficient delivery system would use sparingly. Hospital investments might be designed to preempt control of ACOs, rather than harness their potential efficiencies, so any cost savings will come at the expense of others and not themselves.

In contrast to the varying views on the potential benefits of ACOs, there is widespread agreement that they could engineer and leverage greater monopoly power in an already-concentrated healthcare market.⁴⁸ Organizers of ACOs are

⁴⁶ Alain C. Enthoven and Laura A. Tollen, “Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency,” *Health Affairs* (September 7, 2005), doi:10.1377/hlthaff.w5.420.

⁴⁷ Remarks of J. Thomas Rosch before the ABA Section of Antitrust Law, November 17, 2011.

⁴⁸ See America’s Health Insurance Plans, *Accountable Care Organizations and Market Power Issues* (October 2010), www.ahip.org/Workarea/linkit.aspx?ItemID=9222 (accessed May 25, 2012); Berenson, Ginsburg, and Kemper, “Unchecked Provider Clout” (which notes ACOs’

forging collaborations among entire markets of physicians and hospitals, entities that would otherwise compete with each other. The New York Times has reported “a growing frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings, and cash in on the [ACO program’s] incentives.”⁴⁹ In fact, providers’ main purpose in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen their market power over purchasers in the private sector. ACOs “may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations.”⁵⁰

Antitrust policymakers therefore should carefully scrutinize the formation of ACOs. Conventional antitrust reasoning appropriately permits purported efficiency claims to trump concerns about concentration on the seller side of the market, and any review of a proposed ACO would certainly consider the potential benefits of vertical integration. But any antitrust analysis should also recognize that health insurance greatly exacerbates the price and misallocative effects of monopoly.

Notwithstanding the special efficiency claims that can be made on behalf of ACOs,

“potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power”); and Jeff Goldsmith, “Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms,” *Health Affairs* 29, no. 7 (2010): 1299, 1304. (“Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen.”).

⁴⁹ Robert Pear, “Consumer Risks Feared as Health Law Spurs Mergers,” *New York Times*, November 20, 2010.

⁵⁰ Barak Richman and Kevin Schulman, “A Cautious Path Forward on Accountable Care Organizations,” *Journal of the American Medical Association* 305, no. 6 (February 9, 2011): 602–03.

the potency of healthcare monopolies provides a strong warrant for an especially stringent anti-concentration, antimerger policy in the health care sector. These heightened dangers should be weighed heavily in appraising an ACO's likely market impact.

Antitrust policymakers therefore should carefully scrutinize the formation of ACOs. Conventional antitrust reasoning appropriately permits efficiency claims to overcome concerns about concentration on the seller side of the market, and any review of a proposed ACO would certainly consider the potential benefits of vertical integration. But any antitrust analysis should also recognize that health insurance greatly exacerbates the price and misallocative effects of monopoly.

Notwithstanding the special efficiency claims that can be made on behalf of ACOs, the potency of health care monopolies strongly warrants especially stringent anti-concentration, anti-merger policy in the health care sector. These heightened dangers should be weighed heavily in appraising an ACO's likely market impact.

It remains unclear what role the FTC and DOJ have in applying this necessary level of scrutiny to new ACO proposals. But the antitrust agencies surely enjoy a good deal of discretion in ensuring that ACO complies with the principles of competition. The agencies could demand a heightened showing that a proposed consolidation will generate identifiable efficiencies, and they similarly might demand that an ACO's proponents assume the burden of showing an absence of significant horizontal effects in local submarket. The agencies similarly could impose demanding cures to illegal concentrations, perhaps encouraging the vertical integration envisioned by PPACA's proponents while reducing the horizontal

collaboration that providers so routinely pursue. Finally, the agencies could also impose conduct (i.e. non-structural) remedies to potentially harmful ACOs, such as requiring nonexclusive contractual arrangements with payors and with regional hospitals, or pledging to undo certain integrations if prices proceed to rise above a certain threshold. How the FTC and DOJ monitor the formation of ACOs could determine whether the ACA meaningfully advances a (desperately needed) reorganization of healthcare delivery or merely offers a loophole to permit greater consolidation.

The CMS might also serve a meaningful role in preventing ACOs from furthering anticompetitive harm in healthcare marketplaces. The final rules permit CMS to share savings with ACOs only after a showing of quality benchmarks, which CMS administrators ought to take seriously. The rules also require cost and quality reporting, and CMS might require a demonstration of meaningful quality improvements and cost savings in order to receive a continued share of Medicare savings. CMS might even condition an ACO's permission to market to private payers on a demonstration that its prices to private payers did not increase significantly following its formation.

One might wonder, of course, whether a governmental single payer like Medicare has the mission, the impulse, or the requisite creativity to be helpful in making private markets for health services effectively competitive. Perhaps CMS's new Center for Medicare and Medicaid Innovation could shape the institution's capacity to affect reform. It might be equally likely, unfortunately, that Medicare will aim to preserve its own solvency by encouraging the shifting of costs to the

private sector—and may even reward ACOs’ cost shifting as cost savings. This is the danger with using a large and unavoidably inflexible bureaucracy to engineer an effort to induce innovation. Nonetheless, you go to war with the bureaucracy you have, and CMS ought to concentrate on developing competition-oriented regulations and cautiously monitor the market impact of emerging ACOs.

B. Requiring Unbundling of Monopolized Services

Any effort to restore price competition in healthcare markets must include a strategy that targets already-concentrated markets. Antitrust enforcers therefore need to develop policy instruments that target current monopolists, both to limit the economic harm they inflict and to thwart their efforts to expand their monopoly power.

One promising initiative could be to require hospitals and other provider entities to unbundle, at a purchaser’s request, certain services for the purposes of negotiating prices. Providers routinely bundle services for unified payments, and many such bundles serve efficiency purposes. Some services are so intertwined that separating them proves costly, and similarly, many clinically related services offer efficiencies when sold together. However, when providers bundle services in markets they have monopolized with services in which there is competition, a menu of anticompetitive consequences can result: the monopolist can squeeze out rivals in the competitive market, creating for itself another monopoly; and by squelching rivals in the competitive market, the monopolist limits the ability of entrants to challenge its hold on the monopolized market. The magnified consequences of

healthcare monopolies should heighten concern over practices that can expand or enshrine provider monopolists.

The general antitrust rule on tying is that a firm with market power may not use it to force customers to purchase unwanted goods or services.⁵¹ If this principle is invoked to frustrate hospitals' practice of negotiating comprehensive prices for large bundles of services, purchasers could then bargain down the prices of services with good substitutes.⁵² If a hospital still wished to fully exploit its various monopolies, it would have to do so in discrete negotiations, making its highest prices visible. Health plans could then hope to realize significant savings by challenging such monopolies, either by inducing enrollees to seek care in alternative venues (effectively expanding the geographic market) or by encouraging new entry. Often the mere threat of new entry is sufficient to modify a monopolist's demands, but entry is more credible if the monopolized service is discrete and associated with a distinct price that entrants can target.

To date, there have been only limited enforcement efforts to prevent hospitals from tying their services together in bargaining with private payers.⁵³ Although hospitals would predictably argue that bundling generally makes for

⁵¹ See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984).

⁵² The ability to leverage market power in one sub-market into price increases in a competitive market helps explain wide price variation for like services in common geographic markets. See Paul B. Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," HSC Research Brief no. 16 (November 2010), www.hschange.com/CONTENT/1162/ (accessed May 25, 2012).

⁵³ In a private suit, a dominant hospital chain was sued by its lone rival for, among other things, bundling primary and secondary services with tertiary care in selling to the area's insurers. See *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 890–91 (9th Cir. 2008). The district court permitted certain claims to proceed to trial, including a claim of illegal bundled discounts, but dismissed the tying claim.

efficient negotiating and streamlined delivery of care, the added costs of bargaining service by service could be easily offset by the lower prices resulting from greater competition. Recent scholarship on tying and bundling confirms that permitting a hospital monopolist to tie unrelated services expands the monopoly's reach, profitability, and longevity and harms consumer welfare.⁵⁴ The extreme harm from healthcare monopolies makes hospitals' tying practices particularly vulnerable to antitrust attack.

A workable rule would permit antitrust law to empower a purchaser to demand separate prices for divisible services that are normally bundled.⁵⁵ Although one hopes that antitrust courts and a credible threat of treble damages would discourage a provider monopolist from retaliating against any purchaser that aggressively challenges its anticompetitive practices, the costs and delay from such complex antitrust actions suggest that public enforcement should supplement private suits. Properly authorized regulators could either enable individual payers to demand unbundling to facilitate their efforts to get better prices, or regulators could demand it themselves. Effective unbundling requests could trigger more competition and greater efficiency both in the tied submarkets where monopoly is not a problem and also in the tying markets where it is.

⁵⁴ See Einer Elhauge, "Tying, Bundled Discounts, and the Death of the Single Monopoly Profit Theory," *Harvard Law Review* 123, no. 2 (2009): 397–481.

⁵⁵ This proposal is in line with recommendations from the Antitrust Modernization Commission, *Report and Recommendations* (April 2007): 96, http://permanent.access.gpo.gov/lps81352/amc_final_report.pdf (accessed May 9, 2012). What is "divisible" in health care is of course subject to debate, just as most services accused of being bundled are often defended as a single product. See, for example, *Jefferson Parish Hosp.*, 466 U.S., 19–22.

C. Challenging Anticompetitive Terms in Insurer-Provider Contracts

Restrictive terms in contracts between providers and insurers are another potentially fruitful area for antitrust and regulatory attention in dealing with the provider monopoly problem. A common practice, for example, is for a provider-seller to promise to give an insurer-buyer the same discount from its high prices as any it might give to a competing health plan. Such price-protection, payment-parity, or “most-favored-nation” (MFN) clauses are common in commercial contracts and serve to obviate frequent and costly renegotiation of prices. Their efficiency benefits may sometimes be outweighed by anticompetitive effects, however. Thus, a provider monopolist may find that a large and important payer is willing to pay its very high prices only if the provider promises to charge no lower prices to its competitors. Such a situation apparently arose in Massachusetts, where the Commonwealth’s largest insurer, a Blue Cross plan, reportedly acceded to Partners HealthCare’s demand for a very substantial price increase only after Partners agreed to “protect Blue Cross from [its] biggest fear: that Partners would allow other insurers to pay less.”⁵⁶

Antitrust law can offer relief against a provider monopolist agreeing to an MFN clause to induce a powerful insurer to pay its high prices. Because such clauses protect insurers against their competitors’ getting better deals, many are likely to

⁵⁶ “A Handshake That Made Healthcare History,” *Boston Globe*, Dec. 28, 2008. The Massachusetts attorney general has noted that such payment-parity agreements have become “pervasive” in provider-insurer contracts in the commonwealth and has expressed concern that “such agreements may lock in payment levels and prevent innovation and competition based on pricing.” Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers* (March 16, 2010), 40–41.

give in too quickly to even extortionate monopolist price demands. But the availability of an antitrust remedy (which would probably be only a prospective cease-and-desist order rather than an award of treble damages for identifiable harms) might not be sufficient to deter a powerful provider from granting MFN status to a dominant insurer. Alternatively, regulatory authorities could presumably prohibit dominant providers from conferring such status. Regulators presumably would be in as good a position as any party to distinguish between restrictive agreements that achieve transactional efficiencies from agreements that restrict insurers' freedom to cut price deals with competitors and reduce pressure on, and opportunities for, all insurers to seek new and innovative service arrangements.

A more potent antitrust attack on anticompetitive MFN clauses would aim at the dominant insurer demanding them, rather than at the cooperating provider. The Department of Justice (DOJ) sued Blue Cross Blue Shield of Michigan, a dominant insurer, to enjoin it from using MFN clauses in its contracts with Michigan hospitals. The DOJ alleged that such restrictions on provider price competition reduced competition in the insurance market by preventing other insurers from negotiating favorable hospital contracts.⁵⁷ In the wake of the government's initiative in Michigan, which resulted in a settlement, Michigan (and subsequently several other states) have prohibited the use of MFN agreements between health insurers and providers. Even without state regulations prohibiting MFN clauses, the DOJ theory met sufficient support that in Massachusetts, for example, the Blue Cross

⁵⁷ See Complaint at 1-2, *United States v. Blue Cross Blue Shield of Mich.* (E.D. Mich. 2010) (No. 2:10-CV-14155); see also David S. Hilzenrath, "U.S. Files Antitrust Suit Against Michigan Blue Cross Blue Shield," *Washington Post*, October 18, 2010.

plan should now think long and hard before renewing (or enforcing) the MFN clause in its contract with Partners HealthCare.

Other contract provisions that threaten price competition are also in use in provider-insurer contracts in Massachusetts, according to the Commonwealth's Attorney General. In particular, so-called "anti-steering" provisions prohibit an insurer from creating insurance products in which patients are induced to patronize lower-priced providers. Under such a contractual constraint, a health plan could not offer more generous coverage—such as reduced cost-sharing—for care obtained from a new market entrant or from a more distant, perhaps even an out-of-state or out-of-country, provider. Other contractual terms in use in Massachusetts (and presumably in other jurisdictions as well) guarantee a dominant provider that it will not be excluded from any provider network that the health plan might offer its subscribers.

The contractual terms noted here all have the potential to enshrine the cooperative supremacy of dominant providers and dominant insurers. The resulting competitive hard extends beyond the sustenance of high prices. These partnerships also foreclose opportunities for consumers to benefit, both directly as patients and indirectly as premium payers, from innovative insurance products that competing health plans might otherwise introduce. Antitrust law can prohibit the use of such anticompetitive contract terms that protect provider monopolies and curb insurer innovation, and insurance regulators might bar such provisions wherever they threaten to preclude effective price competition. These actions remain available even in the continued presence of a provider monopoly.

V. Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving insured healthcare consumers exposed to monopolized healthcare markets. Because health insurance, especially as it is designed and administered in the United States, hugely expands a monopolist's pricing freedom, providers with market power inflict wealth-redistributing and misallocative effects substantially more serious than conventional monopoly power.

Vigorous—not tentative or circumspect—enforcement of the antitrust laws can mitigate the harms from provider market power. Retrospective scrutiny on earlier horizontal mergers of hospitals or other providers could help correct decades of ineffectual enforcement, but if looking backwards remains unlikely, renewed rigor moving forward is all-the-more essential. Parties proposing new mergers and alliances, whether traditional associations or new ACOs, must convincingly show that their reorganization either leads to only a minimal increase in market power or creates specific efficiencies. Traditional market definitions should also be expanded, recognizing that interregional collaborations can also reduce competition in growing healthcare markets and can generate additional pricing power. Other measures should target current monopolists, so as to prevent the enshrinement or expansion of their market dominance. An antitrust or regulatory initiative to curb hospitals' tying practices and to prohibit anticompetitive contracts between payers and providers—perhaps as remedies for earlier mergers found unlawful after the

fact—might also reduce and contain the harm from provider pricing freedom. Such policies might curtail monopolist hospitals' ability to enshrine their market position and foreclose entry, to spread their pricing power into adjacent markets, or to extract greater rents from buyers with few alternatives.

Enthusiasts for market-oriented solutions would also seek to restrain provider market power by encouraging creativity among third-party purchasers. Health plans that bypass, or foster new competitors for, local monopolists promote price and quality competition where it is currently lacking and could undermine the potency of insurance-plus-monopolies. A pro-competition regulatory agenda might seek ways to facilitate inter-regional competition and empower third-party payors to seek flexible and creative strategies to stimulate provider competition.

Additional hope lies in the possibility that health insurers and third-party purchasers will purchase (and that ACA regulations will let them purchase) proven non-medical interventions that improve health and reduce healthcare costs. The exorbitant prices for monopolized medical services should encourage health insurers to develop creative alternatives, both seeking effective (and less-costly) substitutes and reorganizing what has become a fragmented, error-prone, and inefficient delivery of care.

Unfortunately, few health insurers have shown an eagerness either to contest provider market power or to pursue meaningful innovations to providing care for their subscribers. As investigations in Michigan and Massachusetts reveal, insurers all-too-often become co-conspirators with provider monopolists, agreeing to exclusive agreements that protect both themselves and monopolists but

unforgivingly gouge consumers. Insurer' failure to act as aggressive purchasing agents of consumers is partly due to the hiding of the true cost of insurance and partly due to consumers' undue reluctance to accept anything less than the very best—even close substitutes. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their insurers. Dominant U.S. health plans appear inadequately incentivized to reduce costs and overly hesitant to adopt innovative strategies with associated legal or political risks. Any hopefulness for the future of U.S. health care is tempered by doubts about the ability and willingness of U.S. health insurers—as well as insurance regulators and elected officials that purchase insurance for public employees—to take the aggressive actions needed to procure appropriate, affordable care.

The ACA, by providing conventionally generous health insurance to many million more Americans, has the potential to aggravate and extend the significant shortcomings of such insurance. Not only does the new law seem to have no effective answer to the problem of provider and supplier monopolies, but its broad extension of coverage is likely to further amplify the uniquely harmful effects of their market power. Moreover, its new regulatory requirements—the impositions of medical loss ratios and essential health benefits, for example—might constrain innovations among payors to create inter-regional provider competition and reconfigure a deeply inefficient healthcare delivery system.

However, the ACA also has the capacity to open up the insurance market. Many consumers will, for the first time, realize the full cost of health insurance, which

perhaps—via sticker shock—induce them to demand lower-cost alternatives. Moreover, the insurance exchanges might offer a platform for new entry in the insurance market, thus injecting some dynamism into an industry desperately in need of creative ideas. And regardless of how the new insurance markets take shape, antitrust policymakers and other regulators still have the capacity to foster value-enhancing innovation—both by preventing tactics that might enshrine the current monopolist regime and also by promoting the development of new insurance products. Although current tax policies and regulations have dulled many insurers into being agents for providers rather than for their subscribers, there remains a potent opportunity for third-party payors to inject the healthcare sector with value-creating innovations that redesign both the offerings and the delivery of care.

Whatever the PPACA may achieve, its legacy and cost to the nation will depend largely on whether market actors, regulators, and antitrust enforcers can effectively address the provider monopoly problem and to instill desperately needed competition among providers. Aggressive antitrust enforcement can prevent further economic harm and perhaps can undo costly damage from providers that in error were permitted to become monopolists. But ultimately, creative market and regulatory initiatives will be needed to unleash the competitive forces that consumers need. Where there is danger, there is opportunity, and competition-oriented policies can and should yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources that appear to become increasingly limited.