

Competition Policy and the Future of Health Care Markets
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Summary: Recent experiences with higher prices from hospital consolidation have induced antitrust enforcement agencies to defend per-service bargaining models between health care providers and health insurers. These practices, however, reflect a quiescent period for innovation in health care delivery, spanning roughly from 1997 to 2010, and are generally considered by health policy experts to have failed consumers. Health care markets are now on the cusp of major changes made necessary by persistently rising health care expenditures, limits on government's long-term fiscal capacity, poor population health, and the recognition that established patterns of financing and delivery have wasted money and shortchanged quality and safety. Change is being accelerated by the Patient Protection and Affordable Care Act of 2010, but is not dependent on that law alone.

The legal evaluation of consumer harm from industry restructuring should be forward-looking, particularly in heavily regulated sectors such as health care where current market conditions do not reflect a private competitive equilibrium. To facilitate change, antitrust law must develop analytics that anticipate and facilitate competitive processes in health care, including a more effective framework for analyzing regulatory influences on market structure, conduct, and performance. Because an optimal approach to competitive oversight in US health

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care would consciously identify and promote specific dimensions and dynamics of competition that have been less than vigorous in the past, rather than assuming that markets will generate their own competitive priorities, this would be a radical departure from existing practice.

Note to Readers: *The goal of this project, which is supported by a grant from The Commonwealth Fund, is to help guide the application of antitrust law to the health care industry as it restructures in response to existing pressures on its financial model and to the initial requirements and likely future direction of federal health care reform. The project will generate a health policy article and a law review article sharpening the legal and regulatory analysis of health care competition in the context of health care reform and helping to develop a new framework for competition policy as health care markets consolidate and change. The health policy article has been submitted to a peer review journal and cannot be circulated for comment. This is an early draft of the law review article. Part I of the draft is relatively well developed, Part II is sketched out but not fully developed, and Part III is still in outline form.*

I. INTRODUCTION

In the last iteration of attempted federal reform in the early 1990s, the Clinton administration's abortive Health Security Act, rapid private marketplace restructuring followed legislative failure but was not tethered to government regulatory or payment policy. Federal antitrust authorities acted in good faith to facilitate market change consistent with legal norms, but discovered as the decade progressed that a public and political backlash against unconstrained managed care and concurrent nostalgia for traditional medical professions and institutions caused several courts to stray from established analytic principles and favor defendants, with predictable effects on the conduct of market participants and the level of

enthusiasm for additional enforcement. Subsequent empirical studies confirmed that consumer welfare generally had not been improved by the market consolidation and integration that occurred during this period of legal forbearance.²

Today, following the successful (though still highly controversial) adoption of sweeping federal health reform in the Obama administration's Affordable Care Act, policymakers face critical decisions about the focus and intensity of future federal antitrust enforcement activities. The intent of this article is to outline a competition policy for American health care that is consistent with generally applicable antitrust law but that works together with regulatory reform to improve market outcomes for health care consumers. This policy must be more than a political and legal settlement between "collectivist" and "free-market" ideologies for control of the US health care system, but must revisit basic questions about who competes in health care, what they compete to provide, and how that competition can be vigorous and successful. Health care markets are on the cusp of major changes made necessary by persistently rising health care expenditures, limitations on government's long-term fiscal capacity, and the recognition that established patterns of financing and delivery have wasted money and shortchanged quality and safety. Market changes are being accelerated by the Patient Protection and Affordable Care Act of 2010 (ACA), but are not dependent on that law alone.

In the United States, legal oversight of competition is accomplished primarily through antitrust law. Antitrust law consists of a small number of federal statutes that authorize the US

² See WILLIAM B. VOGT & ROBERT TOWN, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?, ROBERT WOOD JOHNSON RESEARCH SYNTHESIS REPORT NO. 9 (February 2006); MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE, ROBERT WOOD JOHNSON FOUNDATION (June 2012); D. Kessler & J. Geppert, *The Effects of Competition on Variation in the Quality and Cost of Medical Care*, (National Bureau of Economic Research, Working Paper No. 11226, Fall 2005); D. Kessler & M. McCellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. OF ECON. 2 (2000).

Department of Justice and the Federal Trade Commission, as well as private litigants, to seek sanctions against parties engaging in anticompetitive practices.³

The United States has seen itself as fostering a private, competitive model of health care delivery, rather than the model of government sponsorship through national health insurance that has prevailed in most of the developed world. In fact, this contrast is less stark than it seems, as public purchasing and public regulation have heavily influenced the dimensions and performance of competitive health care markets for decades. In particular, the longstanding fragmentation of health care delivery among both health professionals and health care facilities, and the lack of connection between those two critical sectors, largely came into being and has been perpetuated by government regulation and payment policies

Integration, bundled and episodic payment, and accountability for outcomes through both incentives and transparency are now widely discussed and expected among policymakers and the educated public. Yet antitrust enforcement practices, particularly those involving hospital mergers and other forms of consolidation, continue to emphasize per-service bargaining between health care providers and managed care organizations.

Insurer-provider bargaining emerged in the 1980s, accelerated in the early 1990s, and eventually became a marketplace fixture. Its dominance, however, corresponds with a quiescent period for innovation in health care delivery. Spanning roughly from the beginning of the managed care backlash in the late-1990s to the ACA's passage in 2010, these years of broad provider networks and fee contracting are often considered to have failed consumers.

During this same period, however, the Federal Trade Commission and the US Department of Justice revisited antitrust enforcement efforts from the 1990s that had been

³ Sherman Act of 1890, 15 U.S.C. §§ 1-7 (2004); Clayton Antitrust Act of 1914, 15 U.S.C. §§ 12-27, 29 U.S.C. 52-53 (2013); Federal Trade Commission Act of 1914, 15 U.S.C.A. §§ 41-58 (West 2013).

stymied by public and judicial distrust of managed care and relative comfort with community hospitals and medical professionals. Retrospective reviews of markets in which transactions suspect on antitrust grounds nonetheless had been allowed to proceed suggested that bargained-for prices had increased and promised efficiencies did not materialize.

Today, the entities setting competition policy seem determined not to be fooled again. Yet their analytic framework is based on past practices, not current trends. The enforcement agencies' initial pronouncements about accountable care organizations, for example, were very sensitive to anticompetitive risk and strayed minimally from pre-existing policies.⁴ Instead, the evaluation under antitrust law of consumer harm from consolidation and restructuring should be a forward-looking inquiry, particularly in heavily regulated sectors such as health care where prevailing market conditions do not reflect a private competitive equilibrium and regulatory developments continually change the dimensions and dynamics of competition.

Antitrust law therefore must develop analytics that anticipate and accommodate future competitive processes in health care. An effective competition policy must integrate both market and regulatory governance. In the merger context, this requires more nuanced application of the market definition, market concentration, merger specificity, and efficiencies provisions of the 2010 horizontal merger guidelines. For antitrust enforcement generally, this requires a general framework for understanding the dimensions of competition that require the most encouragement

⁴ In some ways, initial caution is to be expected and does not necessarily portend continued conservatism. The antitrust enforcement agencies issued three joint statements of enforcement policy for health care in the 1990s, representing the agencies' first joint effort at industry-specific guidance. The first policy statements, issued in 1993 in the middle of the Clinton administration's health reform planning process, clearly set forth existing law but did not offer forbearance in connection with health system restructuring in anticipation of national reform. U.S. Department of Justice and Federal Trade Commission, *Antitrust Enforcement Policy Statements in the Health Care Area*, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Sept. 15, 1993). The second and third policy statements, issued in 1994 and 1996, showed greater awareness of industry trends and more openness to altering established enforcement practices. U.S. Department of Justice and Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, 4 Trade Reg. Rep. (CCH) ¶ 13,152 (Sept. 27, 1994); U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care Area*, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 18, 1996).

in health care, and for analyzing regulatory influences on market structure, conduct, and performance in health care that fall short of conferring formal immunity from antitrust oversight. Public regulation coexists with competition in many industrial sectors, yet the interaction between the two governance regimes has seldom been a focal area for competition policy. As the United States embarks on a necessary yet controversial reinvention of its health care system, it is essential to document how the history, structure, performance, and regulatory framework of the health care influence and are influenced by antitrust law.

Extensive regulation is a fact on the ground in health care. Modern hospitals took shape through regulation, and regulation determines to a very large degree which patients have access to hospitals, the quality of care they receive, and the cost of that care. .

- Medicare and other public health insurance programs are essential to understanding how hospital markets function
- Regulation defines the competitive role of private health insurers, and influences how and how much hospitals are paid.
- Regulation defines the relationship between hospitals and physicians.
- Regulation guides the conduct of nonprofit hospitals.
- Regulation largely determines the baseline number of hospitals, challenging conventional assumptions about market concentration

Although health care reform is now under way – the Affordable Care Act having survived both constitutional and political challenges – much antitrust enforcement in the merger context remains based on simple narratives from recent history. Imagine a town in which customers prefer a choice of more than one hospital, and where two of three existing hospitals have decided to merge. If these are large, presently successful organizations, it might seem they

have no legitimate business reason to combine. If there are only two competing hospitals left in the market, moreover, perhaps they will be able to extract higher prices for their services when they negotiate contracts with their apparent customers, private health insurers. The proposed merger, therefore, is likely to be viewed by the antitrust enforcement agencies as creating a significant threat of anticompetitive behavior and resulting harm to consumers.

This entirely plausible story may be wrong. Existing market structures reflect a complex history of professional and governmental intervention in health care, not a competitive market equilibrium, and the style of price negotiation currently prized by US competition authorities represents a transitory phase in health policy that has not produced clear benefits to consumers. Through shifts in public payment and oversight such as the ACA, the regulatory environment is giving clear signals that a major reshaping of hospital markets is necessary and is imminent. These regulatory developments do not create "state action immunity" from antitrust law under established legal precedents, but they are nonetheless extremely relevant to any competitive analysis. Hospitals in medium-sized markets today are facing major changes in demand for their services, in the form and amount of payment available for those services, in the customers who will purchase their services, and even in the very definition of what constitutes their services.

Hospitals and physicians who are paying attention to the direction of health policy understand that expectations of them are evolving rapidly, that they are poorly positioned to fulfill their new responsibilities, and that notwithstanding their past successes they must either change or fail. Recent years have brought the realization that health care in the US is not superior to other countries. The overall quality of care we provide is average, and is plagued by shameful amounts of error, inattention, and waste. Our clinical technologies remain marvels, but we deploy them with appalling mediocrity.

Hospital markets in particular have been productively inefficient because of piecemeal fee-for-service payment, lack of coordinated production, and an overhang of government subsidies that promoted overinvestment in expensive acute care to the detriment of community-based prevention and disease management strategies. Innovation, itself an important competitive outcome, has neglected improvements in the organization of care delivery and the achievement of verifiable health outcomes at the individual and population level in favor of a proliferation of off-the-shelf diagnostic and therapeutic technologies.

It seems likely that consumer welfare in health care markets can be increased by reconfiguring provider and payer competition. However, forcing provider markets to remain artificially fragmented because of conventional antitrust analytics may reduce competitors' incentives and ability to achieve scale economies, accurately measure their clinical performance, offer services jointly with physicians, and accept forms of payment that reward productive efficiency, including safety and quality improvement that ultimately reduces demand for hospital services.

As incentives and organizational structures change, privileging insurance company "purchasers" also may oversimplify the market role of health insurers and other intermediaries, potentially mistaking sellers for buyers and buyers for sellers and disadvantaging true consumers of health services. In many instances, moreover, providers in more concentrated markets may be better able to invest in community health and disease prevention, which are essential to long-term cost control and continued affordability of care. Competitive effects analysis in health care therefore should focus on a proposed transaction's potential to improve cost-efficiency and measurable quality of care in a highly regulated industry where most consumers pay in whole or in part with government dollars and where the terms of regulation are evolving rapidly.

This article will offer a three-part critique and analysis of applying antitrust law to today's health care markets, with potential application to other industrial sectors with substantial but changing regulation. Part I of the article will describe the paradox created by applying standard antitrust analysis to a health care system in the throes of regulatory change, using the limited but timely and important example of hospital mergers. Part II of the article will explore the challenges of defining competitive goals in a market that has proved unable to determine its own goals, not only for hospital and other facility-based services but also for areas such as community-based medical care, health care financing, health information technology, and pharmaceuticals. Part III of the article [when completed] will review the existing framework for antitrust analysis in regulated industries and recommend ways in which antitrust enforcement agencies and courts might better account for the changing health care regulatory environment.

II TENSIONS IN HOSPITAL MERGER ENFORCEMENT

Mergers are only one aspect of competition, and hospitals are only one possible set of merging parties. Nonetheless, the treatment of hospital consolidation in current antitrust enforcement policy offers a useful lens for examining the complex issues that competition policy in health care presents. Hospitals (and physician organizations) appear to be experiencing a wave of consolidation last seen in the early 1990s. Antitrust law played an important role during that period, and is likely to do the same today.

Former Supreme Court Potter Stewart once quipped that the sole consistency he could detect in litigation under Section 7 of the Clayton Act was that the government always won.⁵

⁵ United States v. Von's Grocery Co., 384 U.S. 270, 301 (1966) (Stewart, J., dissenting).

From the late 1980s through the early 2000s, DOJ and FTC lost seven consecutive challenges to hospital mergers.⁶

Why did the government lose? Although the challenges conveyed a clear picture when seen from the economics-driven middle ground of conventional merger analysis, the image evaporated both higher up and lower down. Seen from high ground, the cases seemed backwards. In the prevailing narrative of the time, nonprofit hospitals were good guys even if they happened to be sellers, managed care organizations were bad guys even if they happened to be buyers, and the government should not be helping the latter against the former.⁷ Down in the weeds, within “markets” that were really communities, the merging hospitals enjoyed a high degree of trust, including from the businesspeople who sat on their governing boards and who were also in some sense buyers of health care.⁸ Moreover, in the much less sophisticated market that existed then for economic expertise in antitrust litigation, the defendants were able to create enough noise in the data to disrupt the evidentiary base for a finding of anticompetitive effect. Geographic and product markets turned out to be contestable,⁹ and even substantial increases in concentration might not harm consumers.¹⁰

⁶California v. Sutter Health Sys., 84 F. Supp. 2d 1057 (N.D. Cal. 2000) (Oakland, CA); Tenet Healthcare Corp. v. FTC, 186 F.3d 1045 (8th Cir. 1999) (Poplar Bluff, MO); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997) (Nassau County, NY); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996) (Grand Rapids, MI); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995) (Dubuque, IA); FTC v. Freeman Hospital, 911 F. Supp. 1213 (W.D. Mo.), *aff’d*, 69 F.3d 260 (8th Cir. 1995) (Joplin, MO); FTC v. Hosp. Bd. of Dirs. of Lee County, No. 94-137-CIV-FTM-25D (M.D. Fla. May 16, 1994); *aff’d*, 38 F.3d 1184 (11th Cir. 1994) (Lee County, FL).

⁷ See, e.g., Butterworth Health Corp., 946 F. Supp. at 1302 (W.D. Mich. 1996) (“In the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars.”).

⁸ See, e.g., Butterworth Health Corp., 946 F. Supp. at 1296; Freeman Hosp., 911 F. Supp. at 1222. Even large insurers could be complacent, allowing courts to infer that competitive harm was unlikely. Long Island Jewish Med. Ctr., 983 F. Supp. at 132 (quoting the CEO of a major New York MCO as admitting that the merging hospitals were “doing exactly what they should do ... [to] enable them to deliver a better health care product ... [and] a much more cost effective system.”) (internal citations omitted).

⁹ Tenet Health Care Corp., 186 F.3d at 1051–54; Long Island Jewish Med. Ctr., 983 F. Supp. at 140–43.

¹⁰ See Butterworth Health Corp., 946 F. Supp. at 1295 (describing studies conducted by the defendant’s economic expert, Dr. William J. Lynk, which found that higher hospital concentration benefits consumers by decreasing non-profit hospital prices).

During the 2000s, while the government litigators were licking their wounds and very little of interest was happening in the delivery of health care, economists at the federal enforcement agencies and a larger number of nonpartisan academic researchers stepped in to study both the markets involved in these cases and the more general relationship between provider consolidation and price/quality characteristics. Much of this work was collected by the Synthesis Project funded by the Robert Wood Johnson Foundation, which published a report in 2006 and an update in 2012.¹¹

Following its own post-merger analysis of the Evanston market, the FTC's Bureau of Competition filed an administrative action to challenge the transaction five years after it had been consummated.¹² In 2005, an administrative law judge concluded that the merger should be unwound¹³, but on review the full Commission declined to order divestiture although it agreed the merger was anticompetitive.¹⁴ More recently, the FTC succeeded in obtaining both a preliminary injunction in federal district court and an ALJ determination of anticompetitive effect in connection with a hospital merger in Toledo, Ohio, and a preliminary injunction against a proposed merger in Rockford, Illinois involving some of the same hospitals that it had previously reviewed in the 1980s and 1990s.¹⁵ It would appear that the tide has turned once again in favor of close scrutiny of hospital consolidation.

The narrative had changed as well. Managed care had been defanged, and was no longer considered a public menace. Rather than be seen as limiting choice and rationing care for their

¹¹ See WILLIAM B. VOGT & ROBERT TOWN, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?, ROBERT WOOD JOHNSON RESEARCH SYNTHESIS REPORT NO. 9 (February 2006); MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE, ROBERT WOOD JOHNSON FOUNDATION (June 2012).

¹² Complaint of the Federal Trade Commission, Matter of Evanston Northwestern Healthcare Corp., 2005 WL 2845790 (F.T.C.) (Feb. 10, 2004) (No. 9315).

¹³ Matter of Evanston Northwestern Healthcare Corp., 2005 WL 2845790 (F.T.C.) (Oct. 20, 2005).

¹⁴ Matter of Evanston Northwestern Healthcare Corp., 2007 WL 2286195 (F.T.C.) (Aug. 6, 2007).

¹⁵ FTC v. ProMedica Health Sys., No 3:11-CV-47, 2011 WL 1219281 (N.D. Ohio Mar. 29, 2011); FTC v. OSF Healthcare Sys., No. 11-C-50344, 2012 WL 1144620 (N.D. Ill. Apr. 5, 2012).

own economic benefit, health insurers retreated to the far less threatening role of signing contracts with all the hospitals in a community and negotiating “discounted” rates for each service. Once broad provider networks became standard, hospitals started to bargain back. Because health insurance premiums continued to rise, it seemed that hospitals – particularly the larger, “better” ones – must have as much or more bargaining power than insurers (who in fact did not always have strong incentives to drive hard bargains).

For purposes of the analysis in this article, it is sensible to accept the findings of the RWJF Synthesis Project as correct, as contained both in the Project’s review of underlying research and in its interpretations of those findings. However, the Project is a product of its times, and speaks mainly to the effects of health care consolidation between the Clinton administration’s abortive health care reform effort in 1993-94 and the passage of the Affordable Care Act in 2010. Few of the research studies it cites, moreover, derive clear consumer benefit from lack of US hospital consolidation beyond the routine ascription of increased consumer welfare to reduced prices. As the Institute of Medicine has attempted to quantify, American health care is so routinely wasteful that it is difficult to regard pricing changes alone as evidence of substantial improvement.¹⁶ The exceptions in the Synthesis Project review of research are studies of the mortality effects of competition among UK hospitals. However, these were performed in connection with a newly implemented administered pricing scheme by the NHS that also incorporates other elements of accountability, and may not apply as strongly to hospitals in the US. This article therefore regards the Synthesis Project and the research it cites as a launching point for discussing the performance and legal governance of future health care markets in response to substantial regulatory change.

¹⁶ INSTITUTE OF MEDICINE, BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA (Mark Smith, Robert Saunders, Leigh Stuckhardt, and J. Michael McGinnis eds., 2012) [hereinafter BEST CARE AT LOWER COST] (estimating annual healthcare waste to be at \$750 billion).

This discussion is intended to demonstrate that the analytical approach to hospital mergers that failed in court in the 1990s – often for unjustifiable reasons – is still not the right approach today. Two forces are at work. First, those analytics ignored some deep pathologies in health care markets. Second, to put it simply, times have changed. That does not mean that the current wave of hospital (and physician) consolidation is benign, or that antitrust enforcers should lighten their hand. It does suggest, however, that competitive analysis going forward should be based on somewhat different assumptions and should develop somewhat different tools.

A. Health Care Regulation.

A herd of elephants stalks the competitive landscape, particularly with respect to hospitals, which competition policymakers cannot ignore. The herd represents public regulation of health care, including federal (Medicare) and state (Medicaid) payment policies as well as a host of substantive restrictions and requirements imposed by both levels of government. The elephants have been foraging for generations, but after 20 years of relative stability the herd has begun to dramatically change its behavior and direction. In towns and cities across the country, policies set by government divorced from antitrust law shape the competitive terrain, largely dictating how hospital competition occurs, which parties it involves, what dimensions it emphasizes, and whether it succeeds or fails in generating economic benefits for consumers.

For over a century, health care in the United States was placed largely under the control of the American medical profession, which itself was granted extraordinary privileges to regulate its own clinical and economic conduct.¹⁷ Very little of the regulation adopted under this paradigm promoted competition, and antitrust law seldom policed unregulated activity either. Medical professional activity slowly became subject to federal antitrust law as the financial

¹⁷ PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 79–144 (1982).

stakes grew. However, over fifty years elapsed between the passage of the Sherman Act and its application to the American Medical Association's overt exclusionary policies and it was not until well after the enactment of Medicare that specific transactions involving health professionals became targets for antitrust enforcement.¹⁸

There is general consensus among health policy experts that a competitive health care system is socially desirable. But any competitive analysis must recognize that the existing health care system, particularly modern acute care hospitals, took shape under conditions of medical professional control approved by government, not market discipline. Regulation determines to a very large degree what patients have access to hospitals, the quality of care they receive, and the cost of that care. Hospitals' relationships with physicians are guided by regulation,¹⁹ as are their relationships with insurance companies. So are the services they provide and the revenues they earn.

Much as government regulation of health care has heavily influenced market structure and performance in the past, changes in that regulation will influence market structures and performance in the future. For example, recent CMS directives in connection with the Affordable Care Act call for cost reductions and greater coordination between hospitals, physicians and ancillary care providers in order to meet critical demand for health promotion, disease prevention, chronic care management, and successful treatment of episodes of illness.²⁰

¹⁸ *Am. Med. Ass'n v. United States*, 317 U.S. 519 (1943).

¹⁹ *See, e.g.*, Anti-Kick Back Statute, 42 U.S.C.A. § 1320a-7b (West 2013); Stark Laws I & II, 42 U.S.C.A. § 1395nn (West 2010); False Claims Act, 31 U.S.C.A. §§ 3729-3733 (West 2013); Civil Monetary Penalties, 42 U.S.C.A. § 1320a-7a (West 2013)

²⁰ *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 395 (2010) [hereinafter *Affordable Care Act*] (establishing the Medicare Shared Savings Program for Accountable Care Organizations). The three overarching goals of the Centers for Medicare and Medicaid Services for Accountable Care Organizations are to enable (i) better care for individuals; (ii) better health for populations; and (iii) lower growth in Medicare Parts A and B expenditures. *See Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, 76 Fed. Reg. 67,802, 67,803 (Nov. 2, 2011). CMS has also established the Center for Medicare & Medicaid Innovation, which will test innovative payment and delivery models in order to lower

The federal antitrust agencies are aware of, and cautiously cooperating in, these changes in federal health law and policy. For example, the Federal Trade Commission delivered a prepared statement in December 2010 to the Judiciary Committee of the U.S. House of Representatives regarding health care reform describing its intention using antitrust enforcement to lower prices and foster innovation through competition.²¹

However, neither the FTC nor the US Department of Justice has systematically assessed the environment in which health care competition occurs. The 2010 FTC/DOJ Horizontal Merger Guidelines instruct antitrust oversight agencies to scrutinize the realities of competition in actual markets and not merely rely on conceptual paradigms, whether structure-conduct-performance models or game-theoretic ones, for how competition might or might not happen.²² Yet the Guidelines use far less regulated industries than health care to illustrate their analytic points.²³

The regulatory environment is not a defense to anticompetitive conduct under the antitrust laws except in rare cases where Congress impliedly repeals those laws or states adopt structured alternatives to competition that qualify for “state action” immunity.²⁴ But the regulatory environment is always relevant to where and how competition occurs.

B. Baseline Market Conditions

One reason why antitrust enforcement authorities regard proposals for hospital mergers as a potential departure from market optima is that they treat the current number and size of

costs and enhance quality of care. Stuart Guterman et. al, *Innovation in Medicare and Medicaid Will be Central to Health Reform's Success*, 29:6 HEALTH AFFAIRS 1188, 1188–89 (2010).

²¹ Prepared Statement of the Federal Trade Commission Before the Committee on the Judiciary, United States House of Representatives, Subcommittee on Courts and Competition Policy on Antitrust Enforcement in the Health Care Industry 2 (Dec. 1, 2010) [hereinafter FTC Prepared Statement].

²² U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines §§ 1-2 (2010), available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html> [hereinafter Merger Guidelines].

²³ See, e.g., *id.* at § 4 (providing examples relating to, among other markets, markets for the sale of motorcycles and glass containers).

²⁴ *FTC v. Phoebe Putney Health Sys.*, 133 S. Ct. 1003 (2013).

hospitals in a community as a natural outcome of market competition. To the contrary, existing hospital markets did not result from private competitive processes, but are constructed environments in which competition has been channeled into particular structures and dimensions by government subsidies and restrictions. Hospitals have been artificially subsidized by the government for decades in both their capital investment and their ongoing operations. Even in smaller communities, relatively large hospitals often have proliferated because of federal government policies. Without Hill-Burton funds, tax-exempt bond financing, and Medicare cost-plus and capital cost reimbursement, small and medium-sized communities would have built fewer and smaller hospitals.

Recent hospital merger enforcement appears to view hospital markets entirely through a late 1990s lens. At that time, Clinton health reform had failed, public payers were not innovating, and private insurers seemed to be succeeding by inducing hospitals to compete against one another on price through what was then a novel process of selective contracting. That was possible because hospitals had built up capacity in response to government subsidies and cost-unconscious insurance payment practices, but that capacity was no longer required or rewarded by the market. The same forces that built excess capacity also caused hospitals to proliferate in small and medium-sized geographic markets.

Hospital consolidation today represents a renewed search for efficient numbers and scale not seen since the introduction of Medicare DRGs shocked hospitals into rethinking their business models in the early 1980s. Absent specific evidence that particular hospitals are able to exercise market power and motivated to do so, challenging mergers in medium-sized markets that are consolidating on the basis that they are making it harder for a few private insurers to price bargain is like looking for a lost coin under a lamppost just because the light is better.

Instead of looking at markets that have the biggest problems, one may be inventing problems in markets that happen to be easy to look at. It will often be possible to define relatively narrow product and geographic markets and to show relatively high market shares and large changes in concentration whenever one in three or one in four hospitals ceases to operate as an independent business,²⁵ but one also needs to produce hard evidence that preventing that consolidation will benefit consumers.

For example, current financial condition is a flawed predictor of future success. Existing market concentrations are not sustainable because the external subsidies that have supported them are disappearing. In light of these financial realities, for example, it seems unlikely that smaller communities can continue to support several independent acute care hospitals offering the same services. Forced fragmentation through antitrust enforcement may prevent these hospitals from adapting to new conditions and could accelerate their financial stress and increase their risk of eventual failure. The *Titanic* was a magnificent ship, but it was still sailing directly at an iceberg.

To the extent that expectations of, and constraints on, health care providers are becoming more clearly established, it seems shortsighted to consider current evidence of financial stress as a prerequisite to restructuring that might improve the chance of future success. It may be appropriate for middle-class individuals to “spend down” assets in order to qualify for medical assistance through Medicaid, but it makes less sense for antitrust law or government antitrust enforcement agencies to impose a similar requirement on hospitals. To the contrary, it may be disadvantageous to patients and destructive to communities if nonprofit hospitals are forced to squander valuable assets.

²⁵ Under the Merger Guidelines, virtually any merger involving competitors in a market with four hospitals or less would be “presumptively unlawful.” See Merger Guidelines, *supra* note 22, §§ 4–5.

C. Inertia and Change.

The FTC has cautioned in its public statements not to “ignore the lessons of the last quarter-century” regarding market power and health care costs.²⁶ However, the FTC cites the complex history of hospital markets selectively, focusing on a transient phenomenon of fee-for-service discounting to large health insurers by hospitals with redundant capacity. In its successful enforcement action in Rockford, Illinois, for example, the FTC argued that “the merger would still harm competition ... as health plans would have greater leverage playing three hospital systems off one another rather than merely two.”²⁷ This purchasing dynamic reflects only a small portion of the recent health care past, and it is not representative of the future.

The years between the unsuccessful Clinton reform effort and the enactment of the Affordable Care Act generated few innovations in health care financing or delivery, or in its associated regulation. Negotiating discounts on per-service fees became the modus operandi of private insurers during the 1990s, creating the appearance of short-term gains but doing little to benefit consumers in terms of cost reduction or quality improvement over the longer run. As a result, a major transformation is under way to create very different hospital markets in the 2010s. To understand this direction, more information about the history of health care spending is necessary.

In order to gain critical support from organized medicine, Medicare as enacted in 1965 had several features predisposing to overspending: a pledge of noninterference with medical practice, repayment of hospitals’ reported costs plus a reasonable profit margin and capital cost allowance, separation of hospital coverage from physician coverage (who were to be paid their

²⁶ FTC Prepared Statement, *supra* note 21, at 11.

²⁷ Plaintiff’s Supplemental Post-Hearing Memorandum in Support of Preliminary Injunction at 8, *FTC v. OSF Healthcare Sys.*, 852 F.Supp.2d 1069 (N.D. Ill. 2012) (No. 3:11-cv-50344).

customary and prevailing fees), and claims administration by familiar private carriers and fiscal intermediaries, mainly Blue Cross and Blue Shield plans. Within a few years, the federal government realized that it had grossly underestimated the dollar costs of this generosity as both prices and utilization of services rose rapidly, but the structural damage was already done. Beginning as early as 1972, for example, Congress set in motion a series of increasingly strict penalties for “fraud and abuse,” but these have served as much to deter potentially efficient contractual affiliations between physicians and hospitals as to meaningfully reduce unnecessary care.

The Nixon administration seriously considered universal health coverage legislation based on California-style health maintenance organizations and an employer mandate.²⁸ Ultimately, Congress passed only the Federal HMO Act of 1973, which allowed what was to become private “managed care” to gain a foothold in mainstream employer-based coverage nationally but did not systematically alter the cost trajectory of the health care system or curtail the expansion of the hospital sector or the proliferation of costly new technology.²⁹

In the 1970s, the United States flirted with “health planning” at the national level in order to counter the economic extravagance that was increasingly associated with the construction or expansion of hospitals and their acquisition of expensive technologies that were subsequently overused. Most states adopted Certificate of Need (CON) laws during this period, a few of which remain in effect.³⁰ Many states also adopted rate-setting systems for hospitals as part of

²⁸ For a discussion of the “paradigmatic case of conservative assimilation of reform” that occurred in the early 1970s, see STARR, *supra* note 17, at 393-405.

²⁹ Health Maintenance Act of 1973, 42 U.S.C.A. § 300e (West 1996).

³⁰ For a description of the historical background of certificate of need (CON) laws, summaries of relevant studies on the effectiveness of CONs, and an overview of state CON regulations, see ROBERT J. CIMASI, THE U.S. HEALTHCARE CERTIFICATE OF NEED SOURCEBOOK (2005).

their health planning efforts, nearly all of which have since been dismantled.³¹ The national health planning effort stalled when President Reagan was elected in 1980, as a general deregulatory ideology took hold and improving financial incentives in specific transactions took precedence over centralized capital controls.

Hospitals' incentives for efficiency improved sharply in 1983, when Medicare terminated cost-plus reimbursement for most hospitals and instituted prospectively determined case rates based on diagnosis (DRGs). This forced hospitals to seriously examine their cost structures for the first time, and brought them into potential conflict with physicians over excessive length of hospital stay. Financial management of community hospitals became professionalized, clinical coding of patients' diagnoses and treatments assumed much greater strategic importance, the home health industry was created, and the hospital sector underwent a wave of consolidation aimed at reducing excess inpatient capacity revealed by the new Medicare reimbursement and payment methodologies. Overall health care costs failed to stabilize, however, as technologically sophisticated care was shifted to the outpatient sector, where fewer cultural checks on overuse existed, and the economic recovery sapped further reforms of motivation and support.

The recessionary period of the early 1980s was also a wake-up call for the Medicaid program, which was expanding in scope at the federal level as new needs were identified but which was presenting fiscal challenges for strained state budgets. Also in 1983, California repealed its prohibition on selective contracting between non-HMO health plans and hospitals in order to allow its Medi-Cal program to bargain for lower per diem rates in exchange for assurances of volume. Other states followed, ultimately creating through revised regulation the

³¹ See JOHN E. McDONOUGH, INTERESTS, IDEAS, AND DEREGULATION: THE FATE OF HOSPITAL RATE SETTING (1997).

insurer-hospital bargaining process that sits at the heart of the FTC's concerns in the recent wave of hospital consolidation.

Following another recession in the early 1990s, President Bill Clinton's election renewed interest in national health reform along the Nixon lines of managed care with standardized benefits and an employer mandate. Large, unionized employers were very supportive initially because their workforces were aging, health care costs continued to increase, and accounting rules had changed to require disclosure of their contingent liability for retiree coverage. Comprehensive reform failed politically, however, and government abandoned its leadership position on health care reform. This opened an opportunity for private managed care organizations, most operating through contractual networks of providers, to fill the vacuum using aggressive cost containment strategies such as preauthorization of hospital admission and certain procedures, concurrent review of the necessity of continued hospitalization, selective contracting, primary care gatekeeping, and offering physicians financial incentives to reduce care. For the first time since the 1960s, a generation of for-profit hospitals became major players, many nonprofit Blues plans and a few prominent nonprofit hospitals converted to for-profit status, and a variety of new intermediary organizations such as physician practice management companies sensing the upside potential from a stock market boom entered the fray.

The "managed care revolution" of the 1990s paid lip service to the serious need for delivery system reform that health services researchers and health policy experts had by then identified. It turned out, however, that it was much harder than expected to alter clinical behavior in a system so thoroughly rooted in physician control and so devoid of objective accountability.

Moreover, the broader public had minimal understanding of the underlying problems and no interest in allowing “evil HMOs” to tell their doctors what to do and, more importantly, what not to do should they be seriously ill. By the late 1990s, the majority of states and the federal government had legislated not progressively but regressively, pandering to the popular backlash against managed care with “patient protection acts” that mainly protected physicians. Several states also adopted “any willing provider” or “freedom of choice” laws, which limited the ability of managed care organizations to design tightly managed provider networks.³² When the dust settled, pretty much the only accomplishment the managed care industry could cite publicly was its ability to bargain for discounted fees with health care providers, and the main goal of providers was to hold their own in these negotiations. All in all, this was a disappointing end to a decade that began with high hopes of expanded access, reduced cost growth, and a better overall quality of care.

D. Medicare and Other Public Health Insurance Programs

Product markets in hospital merger cases are usually defined based on purchases made by private health insurers and other private parties. Although public purchasers pay administered rather than negotiated prices, massive government investment in health care renders any analysis of competitive outcomes that focuses only on private market transactions misleading. Indeed, a majority of the roughly \$3 trillion that flows annually through the health care system is public money, once one adds to Medicare and Medicaid local charitable spending, federal subsidies for

³² See, e.g., VA. CODE ANN. § 38.2-3407 (West 2008) (“No hospital, physician or type of provider . . . willing to meet the terms and conditions offered to it or him shall be excluded.”); AL. CODE § 27-45-3 (1988) (“No health insurance policy or employee benefit plan . . . shall . . . [p]revent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the pharmacy or pharmacist of his choice.”). For a discussion of the evolution of “any willing provider” and “freedom of choice” laws, see Fred J. Hellinger, *Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment*, 14:4 HEALTH AFFAIRS 297 (1995).

biomedical research and education, and the tax expenditures associated with nonprofit health care organizations and not treating employer-sponsored health coverage as earned income. Although health care prices and aggregate costs have been rising at rates sufficient to alarm politicians and policymakers since the 1930s, the enactment of the Medicare and Medicaid programs in 1965 markedly accelerated those economic trends, with hospital care consistently being the largest component of health spending. As a result, considerable effort has been expended over the past 47 years attempting to modify the regulatory environment for Medicare in order to reduce cost growth, expand access, and maintain or improve quality.

For reasons of both politics and policy, these regulatory changes more closely resemble a punctuated equilibrium than a process of gradual evolution.³³ There are periods of regulatory inaction, during which private entities that survived the preceding round of policy change transact business under prevailing rules and incentives. At other times, dramatic alterations of Medicare policy (and, to a lesser extent, Medicaid policy) forced hospitals and other health care providers and suppliers to reconfigure and private employer-sponsored health coverage subsequently adjusted to the new regulatory terrain. The United States is currently approaching such a discontinuity in regulation and payment, with profound implications for hospital markets. Public policy, led by the Affordable Care Act and the Medicare program's related commitment to Accountable Care Organizations and medical homes, is shifting away from fee-for-service payment for professional piecework and toward bundled or global payment for measurable improvements in health outcomes. Competition to accomplish the latter is fundamentally different from competition to supply the former.

³³ Niles Eldredge and Stephen J. Gould, *Punctuated Equilibria: An Alternative to Phyletic Gradualism*, in *MODELS IN PALEOBIOLOGY* 82 (Thomas J.M. Schopf ed., 1972) (discussing the theory of punctuated equilibrium).

Medicare is the dominant payer for a majority of hospitals in the United States, and will become even more important as the population ages. Other public purchasing will also be increasing in prominence over the next few years because of the Affordable Care Act, which includes a dramatic expansion of the Medicaid program. Beginning in 2014, any individual whose income does not exceed 133 percent of the Federal Poverty Level will be eligible for Medicaid, with the incremental covered population almost but not entirely funded with federal dollars.³⁴ State Medicaid programs are already under severe financial strain.³⁵ As a result, the ACA's expansion of the eligible population represents both a daunting challenge and a necessary opportunity to reinvent models for delivering health care to economically disadvantaged groups.

Public funding has always come with strings attached. Sometimes, laws explicitly prohibit health care providers from conducting private business differently from public business, such as the broad restrictions on financial transactions that are imposed on parties by the fraud and abuse laws governing federal health programs.³⁶ More generally, hospitals design their clinical and financial workflow to comply with the rules and respond to the incentives established by Medicare or Medicaid, and private payers routinely adopt standards and practices based on government benchmarks.³⁷

Because Medicare is an essential funder of nearly all hospitals in the U.S., it serves as a benchmark for both the amount paid by private insurers and the payment methodology they

³⁴ Affordable Care Act, Pub. L. No. 111-148, § 2001(a), 124 Stat. 271 (2010).

³⁵ LAURA KATZ OLSON, *THE POLITICS OF MEDICAID* 229 (2010) (“In the twenty-first century alone, financially strapped states have had to grapple with severe budgetary short-falls from 2001 to 2004 and again beginning in 2008, when more than 60 percent could not discharge their [Medicaid] commitments.”).

³⁶ *See, e.g.*, Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) (prohibiting the exchange, or offer of exchange, of any remuneration to reward, or induce, referrals of business for federal health care programs, including Medicare and Medicaid).

³⁷ Jay Hancock, *New Insurer-Hospital ACO Touts Early Success*, KAISER HEALTH NEWS (Mar. 8, 2012), <http://capsules.kaiserhealthnews.org/index.php/2012/03/new-insurer-hospital-aco-touts-early-success/> (describing the successes of the Illinois-based Accountable Care Organization, AdvocateCare). The creation of an ACO entity between a health system and a private payer underscores the effect of these government-based care delivery models on the private payer industry.

employ. Sometimes this occurs because government takes the lead, as in the Medicare PPS (DRG) system, which was tested at the state level and then adopted federally.³⁸ At other times, it occurs because government, for political or pragmatic reasons, models its practices on those already in place in the private sector, as with the adoption of Medicare in 1965. Regardless, private insurers, including those negotiating with the merging hospitals, often employ (in addition to discounts off “charges” for certain services) a mix of payment approaches based on government programs, such as explicit percentages of Medicare DRG payments, or per diem rates similar to those used by Medicaid. For this reason, it is virtually certain that as Medicare changes its payment approaches, private insurers will pursue similar purchasing strategies.³⁹

Because of government payment policies and associated regulation, prices for hospital care and other medical services have long departed from the norms of competitive markets. This fact alone has serious adverse consequences for efficiency. In the early 1930s, \$4 bought a night in the hospital, and hospitals apologized to patients for surcharges of a few cents necessitated by “new state and federal regulations.” Succeeding decades brought a rapid expansion of Blue Cross plans run collectively by hospitals to assure their solvency during the Great Depression, separation of hospital service plans from insurance coverage of physicians’ fees, pass-through reimbursement of charges by indemnity insurers with legal restrictions on selective contracting in many states, federal Hill-Burton funding for hospital construction linked to charitable care obligations, federal tax subsidies for employment-based health insurance that further attenuated

³⁸ Katharina Janus & Lawrence D. Brown, *Medicare as Incubator for Innovation in Payment Policy*, 32 J. HEALTH POL. POL’Y & L. 293, 298 (2007) (discussing the adoption by the federal government in 1983 of Diagnosis Related Groups (DRGs), which were modeled off a successful program administered by the New Jersey Department of Health in the late 1970s).

³⁹ See, e.g., Robert A. Berenson & Rachel A. Burton, *Policy Brief: Next Steps for ACOs*, HEALTH AFFAIRS (Jan. 31, 2012) http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_61.pdf. (noting that, while ACOs are typically viewed as primarily a Medicare program, Medicare’s approach is already affecting the way in which private health plans pay providers, with nearly 100 medical groups on track to become ACOs).

price-consciousness, and the enactment of Medicare and Medicaid. For its first 15 years of existence, Medicare paid hospitals on a cost-plus basis, with separate funding streams for operating and capital expenses, before shifting in 1983 to a prospective payment system per admission with fixed fees based on patient diagnosis and phasing out additional capital support.

The overall effect of this regulatory environment has been to disaggregate hospital care into the smallest possible units of service, promote rapid adoption of new technologies and freeze their prices at high initial levels, encourage hospitals to incur reportable and therefore reimbursable costs, and create an equally stylized set of “charges” of uncertain relationship to reported costs. In aggregate terms, moreover, hospital prices were poor predictors of overall hospital spending because the volume of services – which included both the decision to hospitalize and the intensity of treatment once hospitalized – remained under the discretionary control of physicians who were subject to an entirely different set of financial and non-financial incentives.

E. Health Insurance

Recent antitrust enforcement proceedings have analyzed interactions between commercial health insurers and hospitals as simple negotiations between buyers and sellers to purchase medical services at agreed upon, “discounted” fees. That is an oversimplified view that narrowly reflects the contracting practices of the last fifteen or so years, a period devoid of major regulatory innovation, and disregards the direction clearly set for the future of the Medicare and Medicaid programs by the Affordable Care Act.

Taking a longer view of health care markets, commercial insurers are not ordinary buyers of medical services. Private health insurers are purchasing intermediaries, not actual consumers of health care. They package care both paid for and used by others, and look out for their own

economic interests. They have strong incentives to maintain their existing market role and business practices. Many are for-profit organizations facing limited competitive pressure. Whether to comply with regulation or to avoid controversy, many health insurers avoid direct participation in clinical care and focus their attention on negotiating fees for conventional services. In many markets, hospitals have discounted fees to the largest private health insurers but have neglected for measures that could move overall costs down, such as investing in innovative approaches to community health.

Antitrust enforcement, therefore, must be based on more than the notion that hospitals (or other health care providers) should organize and operate themselves so as to require the least additional work from commercial insurers. Insurers are at best buyers' agents, at worst self-interested middlemen. It will undoubtedly be easiest for insurers if each community has several wonderfully equipped hospitals that are under-utilized and willing to cut the price of everything from what it required to be paid under current contracts. Massive public subsidies for health care from World War II through the 1990s created conditions of hospital overcapacity that promoted discounting, but they are neither natural nor sustainable. Going forward, real buyers (employers and employees, individually insured persons, and patients) will want the best value in health care. They will not want insurers to do business as usual, obtaining steeper discounts from hospitals that they may or may not pass along to their customers, while overall health care costs continue to climb.

Much of the business of “managed care organizations” is not even true insurance, in that they bear little risk of loss because they administer coverage for self-insured employers or base their premiums on highly predictable annual group “experience.” Functionally, they could as reasonably be regarded not as buyers from hospital systems but as in competition with those

systems to arrange for comprehensive health care at affordable prices. Arranging for comprehensive health care through owned or contracted providers was the expected role for health maintenance organizations from the 1970s into the 1990s, and is a likely outcome of the current move toward Accountable Care Organizations and similar models of coordinated services with bundled or global payment. Before managed care devolved into insurer-provider bargaining toward the end of the 1990s, for example, hospital companies such as Humana developed or acquired insurance businesses, which they operated alongside their provider businesses as a vertical integration strategy. After the public backlash against that generation of managed care, integration receded as a corporate goal and the insurer and hospital businesses were separated again, for fear that unaffiliated hospitals (who had gained influence) would decline to do business with an insurer connected to a competitor.

The future of health insurance beyond claims processing is uncertain. Among other things, the Affordable Care Act mandates the establishment of health insurance exchanges across the country to broker coverage for individuals and small employers.⁴⁰ Health plans participating in these exchanges will operate under very different rules from current health plans, as by offering standardized products that include “essential health benefits” and complying with a blanket prohibition on medical underwriting.⁴¹

F. Hospital-Physician Relations

Although inpatient services are an important consideration in market concentration analysis, considering them in isolation is an inaccurate way to conceptualize the product that health care systems will be expected to deliver in the future under planned payment and accountability models. What will be produced is health care (and even actual health, at least to a

⁴⁰ Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 173 (2010).

⁴¹ *Id.* § 1302 (essential health benefits); *Id.* § 1201 (prohibition on underwriting).

much larger degree than currently). To produce health care efficiently, much more of it will be delivered outside of the traditional acute care hospital, whether in conventional ambulatory sites or at more innovative locations distributed throughout the community.⁴² Inpatient hospital services will not be purchased in isolation of these other services, because doing so has proved both too costly and insufficiently effective. These changes are already under way, particularly efforts to avoid readmissions and to substitute outpatient for inpatient care more generally.⁴³

In recent enforcement proceedings, the FTC has claimed that Accountable Care Organization models such as Medicare’s Pioneer and Shared Savings Programs envision only “vertical” integration between hospitals and physicians and not “horizontal” consolidation of hospitals.⁴⁴ This mischaracterizes the physician-hospital relationship and shortchanges the potential efficiency gains from new financing and delivery models. Because U.S. hospitals have a self-governing medical staff, which is generally required for Joint Commission accreditation, most physicians are legally separated from hospitals but functionally placed within and among them through voluntary affiliation.

Physicians and nonprofit hospitals would have a very different economic relationship in the absence of regulation. For most of the past half century, physicians have been hospitals’ de facto customers because hospital utilization and revenue generation depend on physician decision-making. A physician (not an insurer) has almost always been the patient’s “buying”

⁴² See Cynthia Napier Rosenberg et al., *Results from A Patient Centered Medical Home Pilot at UPMC Health Plan Holds Lessons for Broader Adoption of the Model*, 31:11 Health Affairs 2423 (2012) (describing the innovative delivery of health care through patient centered medical homes).

⁴³ Bruce Japsen, *Though Obamacare Pays Less, Providers Flock to “Bundled” Medicare Payments*, FORBES (Feb. 1, 2013), <http://www.forbes.com/sites/brucejapsen/2013/02/01/though-obamacare-pays-less-medical-providers-flock-to-bundled-medicare-payments/>; Jordan Rau, *Hospitals Face Pressure From Medicare to Avert Readmissions*, NYTIMES.COM (Nov. 26, 2012), <http://www.nytimes.com/2012/11/27/health/hospitals-face-pressure-from-medicare-to-avert-readmissions.html>.

⁴⁴ FTC v. OSF Healthcare Sys., No. 11-C-50344, 2012 WL 1144620 (N.D. Ill. Apr. 5, 2012); see also U.S. Department of Justice and Federal Trade Commission, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 21,894 (Oct. 28, 2011).

agent for hospital care. This dynamic has had deleterious effects on the productive efficiency, cost-effectiveness, and aggregate expense of medical care, particularly in communities with several competing hospitals. It is reasonable for patients to rely on their primary care physicians for guidance on when hospitalization is necessary and for referral recommendations. The problematic aspect derives from the proliferation of community hospitals in the United States in emerging towns and cities across the country as populations migrated and grew. Most of these hospitals were founded through private philanthropy, and adopted “open” medical staff models that allowed not only primary care physicians but also medical specialists in independent office practice to admit patients to the hospital, treat them using the hospital’s technology and staff, and bill separately for the services rendered. This arrangement, which predisposes to high medical spending but does not improve quality, exists only in the U.S. and Canada. Elsewhere, specialist physicians are typically hospital employees and community practitioners lack hospital privileges.

Several inflationary consequences flow from American physicians’ unique prerogatives to use hospital resources. First, hospitals have been obligated to compete not merely for admissions, but for the allegiance of physician specialists. That has led to the duplication of expensive technology that must then be overutilized in order to justify its purchase. Second, specialist physicians have been able to remain in undercapitalized solo or small group practices with inadequate information systems and idiosyncratic practices because much of their capital costs are being funded by hospitals. Third, co-production of medical care within hospitals has been inefficient because independent physicians are treating patients with insufficient coordination among themselves or with the facility. Fourth, physicians being courted by hospitals have had reduced incentives to avoid hospitalization and to care for patients in less expensive settings.

In several states, including California and Texas, the corporate practice of medicine doctrine limits direct employment of physicians by other entities, making more difficult the seamless co-production of medical care by health professionals and health facilities working together.⁴⁵ More importantly, separate streams of third-party insurance payment (“reimbursement”) flow to facilities and to health professionals, a partition established in the early days of health insurance because of hospitals’ greater need to assure payment for serious illnesses and physicians’ resistance to corporate control in any form. In order to blunt the AMA’s opposition to “socialized medicine,” Medicare replicated this division of payment. As a result, hospitals and physicians are seldom financially aligned in their clinical or managerial decisions.

In the last few years, employment of physicians by hospitals has grown rapidly in states that permit it.⁴⁶ This will undoubtedly alter the traditional role of physicians as patients’ buying agents for hospital services and prompt a regulatory adjustment, much as occurred after managed care organizations instituted primary care physician gatekeeping and strict preauthorization requirements to constrain and channel hospitalization. Still, even the employed physician’s contribution to patient care is not exactly an input for the hospital’s output, nor is the hospital’s contribution exactly an input for the physician’s output. Even hospitals that employ substantial numbers of physicians are just beginning the process of truly integrating those physicians into their financial and clinical operations. The best one can say is that physicians and hospitals remain generally non-exclusive co-producers of many medical services. Hospital and physician

⁴⁵ See, e.g., TEX. OCC. CODE ANN. §§ 155.001, 155.003, 157.001, 164.052, 165.156; *Flynn Bros., Inc. v. First Med. Assocs.*, 715 S.W.2d 782, 785 (Tex. App.—Dallas 1986, writ ref’d n.r.e.); CAL. BUS. & PROF. CODE §§ 2400, 2052 (West 1980); *People v. Cole*, 135 P.3d 669, 672 (Cal. 2006); N.Y. EDUC. LAW § 6522 (McKinney 2006); *People v. Woodbury Dermatological Inst.*, 85 N.E. 697 (N.Y. 1908). In 1997, the Illinois Supreme Court clarified that licensed hospitals (but not other corporations) could legally employ physicians. *Berlin v. Sarah Bush Lincoln Health Ctr.*, 688 N.E.2d 106 (Ill. 1997).

⁴⁶ AMERICAN HOSPITAL ASSOCIATION, *AHA HOSPITAL STATISTICS: 2012 EDITION* (2012).

services are indeed “complementary,” but coordinating them more efficiently will require substantial additional changes to hospital structures as well as to physician affiliation and employment practices.

Accountable Care Organization proposals contemplate these co-producers working together more efficiently because of greater transparency, stronger accountability metrics, and better-designed incentives. Such proposals correctly endorse competition among ACOs in communities that can support more than one ACO, but do not simply assume that each existing hospital in a community will draw primary care physicians into orbit around it and survive on the specialized business they refer. That model failed in the early 1990s, when managed care organizations instituted crude “gatekeeping” requirements to reduce direct access to physician specialists and hospitals responded by building satellite clinics and acquiring primary care practices to keep the patients coming. Instead, all the health care providers participating in ACOs, including hospitals, specialist physicians, and primary care physicians, will need to radically rethink their assumptions about how best to organize themselves to care for patients efficiently and effectively.

In recent litigation, the FTC separated markets for inpatient hospital services from markets for primary care physician services in alleging the likelihood of harm to consumers from the merger of two hospitals with employed physicians.⁴⁷ This product definition has a superficial appeal because of the long history of fee-for-service “reimbursement” with independent billing for professional and facility fees in both outpatient and inpatient settings. But it fails to capture the intent of Medicare’s new care and payment models, which place a heavy emphasis on community-based prevention and management of chronic disease – the dominant

⁴⁷ Complaint for Temporary Restraining Order and Preliminary Injunction, *FTC v. OSF Healthcare Sys.*, No. 11-CV-50344, 2011 WL 6917813 (N.D. Ill. Nov. 18, 2011) (No. 11-CV-50344).

source of medical need in the United States today – to reduce the frequency of inpatient acute care.⁴⁸ When acute care is needed, these models require it to be provided in a tightly coordinated fashion under common financial incentives that reward success in achieving cure or stabilization and not merely effort.⁴⁹

Medicare’s new programs rely on health care providers to accomplish these objectives for Medicare beneficiaries, not a massive expansion of Medicare Advantage plans coordinated by private insurers. These providers are expected to develop, and to deliver to patients, novel products that restructure and replace conventional notions of what medical services are bought and sold. These examples might include health management systems that integrate health care expertise with chronic patients’ everyday activities through electronic health records and environmental monitoring, fully warranted acute care that offers a full course of treatment and follow-up care from an interdisciplinary team of health professionals and facilities for a single price, and personalized medicine resources that use genetic information about individual patients to assess risks and potential benefits and enable the creation of customized preventive and therapeutic strategies over each patient’s lifetime.

G. Nonprofit Hospitals

Empirical studies of markets that concentrated during the 1990s suggest that, contrary to the beliefs of some judges hearing antitrust challenges to mergers, nonprofit hospital can both acquire and exercise market power to the detriment of consumers.⁵⁰ For example, there appears

⁴⁸ For example, through its authority granted under Section 3021 of the Affordable Care Act, the CMS Center for Medicare & Medicaid Innovation created the Comprehensive Primary Care Initiative, which is designed, in part, to encourage primary care in an effort to reduce preventable hospitalizations. *See* MELINDA ABRAMS ET AL., REALIZING HEALTH REFORM’S POTENTIAL: HOW THE AFFORDABLE CARE ACT WILL STRENGTHEN PRIMARY CARE AND BENEFIT PATIENTS, PROVIDERS, AND PAYERS, COMMONWEALTH FUND (January 2011).

⁴⁹ *See* ROBERT WOOD JOHNSON FOUNDATION, BUNDLED PAYMENT: THE QUEST FOR SIMPLICITY IN PRICING AND TYING PAYMENT TO QUALITY (June 2013).

⁵⁰ G. Melnick et al., *The Changing Effects of Competition on Non-profit and For-profit Hospital Pricing Behavior*, 18:1 J. HEALTH ECON. 69 (1999).

to be no systematic relationship between the fee-for-service prices charged by hospitals and their status as charitable or proprietary entities.⁵¹ Nonetheless, the goals of nonprofit hospitals, and their consequent behavior, may be markedly different from those of their commercial counterparts, particularly those that are publicly traded. Nonprofit hospitals may eventually become true patient care businesses, but their roots are as community resources and physicians' workshops.

Economists have described nonprofit hospitals as “output maximizing” in their “objective function,” capturing the idea that nonprofit hospitals seek to deliver as many medical services as possible without jeopardizing their solvency.⁵² Nineteenth century hospitals were entirely charitable, serving the poor without charge but, consistent with the medical science of the day, providing little beyond compassion and comfort. The development of modern surgery made the hospital useful to paying as well as indigent patients, but nonprofit hospitals (whether longstanding civic institutions or hospitals with religious affiliations) retain strong senses of mission and identity, are governed by community boards that value reputation above revenue, and by and large have adopted modern management techniques through necessity more than ambition.

The behavioral expectations of nonprofit hospitals are captured, albeit imperfectly, by state and federal tax and corporate law. Nonprofit hospitals must be organized and operated exclusively for charitable purposes, may not distribute earnings to private parties, and must provide community benefit through activities such as serving the poor, maintaining an open

⁵¹ D. Dranove & R. Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18:1 J. HEALTH ECON 87 (1999).

⁵² Jill R. Horwitz Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28:5 J. HEALTH ECON. 924 (2009).

emergency department, and allowing community physicians to join their medical staffs.⁵³ Most importantly, nonprofit corporations are legally obligated to reinvest revenues in operations rather than paying them as profits to owners.⁵⁴ The prohibition on private shareholding also implies that nonprofit hospitals need only support current operations and repay long-term bondholders from revenues in order to survive, and need not meet short-term earnings targets or impress the public equity markets with rapid growth, as would be true of for-profit hospitals. In recent years, moreover, community benefits and other indicia of nonprofit performance have been made more tangible through detailed reporting requirements (e.g., Section 9007 of the ACA) and, in some states, specific quantitative minima.⁵⁵

These constraints on the profit-seeking behavior of nonprofit hospitals have been a mixed blessing for U.S. health policy. Nonprofit hospitals have helped maintain access to unprofitable services, but have also catered excessively to the preferences of physicians on whom they depend for admissions. Nonprofit hospitals have contributed massive amounts of uncompensated care, but have failed to avert far more massive inefficiencies in the production of hospital services, the assurance of clinical quality and safety, and the coordination of care with other providers and settings.

In sum, hospital consolidation and related anti-merger activity does not present a linear story line of consistent enforcement, self-serving defenses, and previously misguided judges who now see the light. The regulatory underpinnings of the US health care system have complicated

⁵³ I.R.C. § 501(c)(3) (2010).

⁵⁴ *Id.*

⁵⁵ Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 855 (2010). In addition, Section 9007 of the Affordable Care Act requires tax-exempt hospitals to (i) conduct a community health needs assessment at least once every three years, (ii) make financial assistance policies widely available; (iii) comply with new billing and coding restrictions; and (iv) limit charges for emergency or other medically necessary care. *Id.*

the analysis of mergers past, and the likelihood of major changes in health care regulation make conventional merger analysis even less reliable going forward.

III HEALTH REFORM AND THE FUTURE OF COMPETITION

Health care reform, including improved competition, greater productive efficiency, and enhanced consumer value, is no longer optional for the United States. Health care cost growth has never been intuitive to average Americans, who focus on out-of-pocket spending until serious illness hits, and then are overwhelmed. However, historical trends in overall health care costs are not sustainable, and as President Richard Nixon's economic adviser Herbert Stein famously said, "If something can't continue forever, it will stop."

Experts agree that rising health care spending is no longer merely the price of scientific progress or the consumption preference of a prosperous and powerful nation, as in the 1980s. Nor is it primarily a choice between accepting inequity or accepting higher taxes and associated bureaucracy, as in the 1990s. It has become a hard constraint on public money available for other critical needs, such as education, a drain on employment compensation that crowds out cash wages, and a long-term threat to the fiscal stability of the United States. Opponents of reform deride the Obama administration's claim to pursue deficit reduction through health reform, but health care remains the only sector in which achievable efficiencies yield savings exceeding full percentage points of GDP.

Consumer welfare can be greatly increased by reconfiguring health care delivery – particularly with respect to hospitals, which consume the largest slice of the health care dollar. Consumer welfare is based on the total cost of providing care, not prices for individual services. This is not merely a matter of averaging loss leaders with cash cows. Unlike a supermarket's customers, shoppers for health care do not simply select items of service, some inpatient and

others outpatient, to place in their carts. Rather, inpatient care and community-based outpatient services will represent two parts of an efficient supply chain for avoiding and treating illness on a comprehensive basis. People may desire more fruit, or meat, or cookies; they never want more inpatient hospitalizations. Similarly, service volume is misleading as an indicator of market output in health care markets because past incentives have rewarded volume over quality and efficiency. Many individual services purchased on behalf of consumers waste resources without reducing mortality or morbidity.

For example, there are huge efficiency gains to be realized when health care delivery systems, under pressure from Medicare, finally learn to regard inpatient hospitalization as a cost center and not a profit center. This requires reversing the incentives that have long promoted overbuilding and overinvestment in expensive acute care technologies to the detriment of community-based prevention and disease management strategies. Preliminary efforts in a similar direction occurred in the early 1990s, but the failure of health reform followed by a political backlash against managed care stopped the momentum.

A. The Patient Protection and Affordable Care Act

The political impetus for a new vision of competition based on clinical outcomes and value-for-money is the passage of the Affordable Care Act in 2010, which despite continued controversy over its implementation represents the successful culmination of a 100-year effort to universalize health coverage in the United States. But the conceptual impetus is even more powerful and less contingent: the realization that American medical care is not superior to that in other countries. To the contrary, the cost of U.S. health care is outpacing both our wealth and any measure of value it provides, while our basic health indicators lag the developed world.⁵⁶

⁵⁶ WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS: 2013, 46–145 (2013) (detailing global health indicators by country), available at

One reason for this poor performance is that innovation, an important competitive outcome, has neglected improvements in the organization of care delivery and the achievement of verifiable health outcomes at the individual and population level in favor of a proliferation of off-the-shelf diagnostic and therapeutic technologies that are not welfare-enhancing in the many instances when they are improperly deployed. Antitrust enforcers assert a desire to preserve innovation through competition, but the most important innovations in health care delivery will focus on better ways to deploy new technology, not just the technology itself, and will require both acute care consolidation and integration between hospitals and physicians.

The Affordable Care Act includes or references the following programs and requirements that are intended to reinvent and improve health care delivery. Some operate through rules; others operate through incentives. Some affect hospitals and health care providers directly; others influence providers indirectly through health insurance or other industry subsectors.

- a. Essential Health Benefits⁵⁷
- b. Zero cost-sharing for US Preventive Services Task Force A or B-rated services⁵⁸
- c. Patient-Centered Outcomes Research Institute (PCORI) (comparative effectiveness research)⁵⁹
- d. Independent Payment Advisory Board (Medicare)⁶⁰
- e. Accountable Care Organizations (Medicare Shared Savings Program)⁶¹
- f. Patient-Centered Health Homes (Medicaid)⁶²

http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf; Gerard F. Anderson et al., *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22:3 HEALTH AFFAIRS 89 (2003). See also BEST CARE AT LOWER COST, supra note ___.

⁵⁷ Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 163 (2010).

⁵⁸ *Id.* § 4003.

⁵⁹ *Id.* § 6301.

⁶⁰ *Id.* § 3403, 10320.

⁶¹ *Id.* § 3022.

⁶² Affordable Care Act, Pub. L. No. 111-148, § 2703, 124 Stat. 319 (2010).

- g. Bundled (episodic) payment pilot for acute and post-acute care⁶³
- h. Center for Medicare and Medicaid Innovation (CMI) to test new, budget-neutral models for care delivery and provider payment⁶⁴
- i. Hospital value-based purchasing program (Medicare pay-for-performance)⁶⁵
- j. Expanded Medicare Hospital Quality Reporting Initiative⁶⁶
- k. Expanded Medicare Physician Quality Reporting Initiative⁶⁷
- l. Independence at Home demonstration to avoid hospitalization (Medicare)⁶⁸

Although it is unlikely that all of these programs will be implemented as enacted, the ACA is sufficiently developed and aligned with industry trends that it is fair to say that health care system has come to a crossroads and has embarked down a new path. [EXPLAIN THE ALIGNMENT WITH INDUSTRY TRENDS IN A PARAGRAPH WITH CITATIONS]

This is particularly true for the hospital sector. Hospital competition going forward will be very different than it was in the 1990s. The overall intent is to reduce the tendency of fragmented insurance coverage, payment incentives, and health care delivery structures to work at cross-purposes in terms of aggregate cost and quality. For hospital care, this means creating strong inducements, both financial and organizational, to avoid expensive inpatient care and, if it becomes necessary, to provide it as safely and cost-effectively as possible.⁶⁹ Despite many uncertainties associated with implementing the ACA, these changes by and large are not

⁶³ *Id.* § 3023.

⁶⁴ *Id.* § 3141.

⁶⁵ *Id.* § 10326.

⁶⁶ *Id.* § 3001.

⁶⁷ Affordable Care Act, Pub. L. No. 111-148, § 3002, 124 Stat. 363 (2010).

⁶⁸ *Id.* § 3024.

⁶⁹ *Id.* § 3025 (detailing the Hospital Readmissions Reduction Program, which requires CMS to reduce DRG payments for Inpatient Prospective Payment System (IPPS) hospitals with excessive readmissions).

speculative. They are consistent not only with the new law, but also with other federal programs and policies and with the business plans of many large employers and private insurers.

It is likely that public payers once again will be the major drivers of market performance. Hospitals configure their business operations to meet the needs of their principal customers, which are Medicare and other government programs, regardless of whether pricing is administered, negotiated, or bid competitively. This happened after Medicare PPS (DRGs) was implemented in the early 1980s, as well as when state Medicaid programs adopted selective contracting later that decade. It will happen again with the adoption of newer payment methods, collaborative structures (e.g., ACOs, medical homes) and quality benchmarking practices. This reconfiguration of the hospital sector will be beneficial to patients as the ultimate consumers, and will improve the products and quality-adjusted pricing available to private health insurers. Over the longer term, price will be lower and quality higher for individuals with private health insurance if hospitals structure themselves to meet the new demands of public payers than if they do not.

Both public and private payers will demand different products from hospitals, such as bundled hospital and physician services for episodes of illness and comprehensive management of the health of nearby populations. Moreover, hospitals will only be able to deliver these products and be paid for them if they can measure and report their performance and the performance of their associated physicians and other health professionals.⁷⁰ In the *Marshfield Clinic* case (7th Cir. 1995), Chief Judge Posner defended the Clinic's size and scope on the

⁷⁰ For example, Section 3025 of the Affordable Care Act implements the Hospital Readmissions Reduction Program, which will decrease Medicare DRG payments, beginning in Fiscal Year 2013, for certain hospitals with high readmissions rates Affordable Care Act, Pub. L. No. 111-148, § 3025, 124 Stat. 408 (2010). The Affordable Care Act also expands the use of pay-for-performance initiatives in Medicare. *Id.* § 10326.

⁷⁰ *Id.* § 3024.

grounds that smaller providers would be “competing to provide horse-and-buggy medicine.”⁷¹ Similarly, a standalone hospital today that is unable to combine its services with those of physicians or adopt new organizational structures and information systems would be competing to provide overly expensive, insufficiently effective “20th century medicine,” not the high-quality, cost-effective health care needed in the 21st century.

Although choice will remain an important dimension of quality in health care, the political settlement following the managed care backlash favoring very broad but largely unmanaged provider networks given the appearance of affordability through price discounting is not a sound model for the future. The economic boom of the 1990s and early 2000s collapsed, but health care costs continued to climb. As a result, broad-network HMO products with minimal cost-sharing – which were common in the late 1990s – are now unaffordable and, in most markets, unavailable. The choices today are either non-HMO insurance products with substantially increased cost-sharing by enrollees, or narrower HMOs in which care is more tightly managed. The latter option is making a market comeback. The newer generation of managed care plans also includes intermediate forms, such as tiered networks with differential cost-sharing.

B. The Need to Channel Competition

Proposing a competition policy to promote particular changes in health care may seem counterintuitive. Competition usually determines its own goals. Rational buyers seek low prices for what they want, and what they want depends on how they weigh price against non-price characteristics such as quality, variety, and convenience. Rational sellers aggregate and respond to these preferences, and in turn make similar requests of their suppliers. Often gradually, but sometimes suddenly, the nature of what is bought and sold changes as the result of innovation in supply and/or demand.

⁷¹ Blue Cross & Blue Shield United of Wisc. v. Marshfield Clinic, 65 F.3d 1406, 1412 (7th Cir. 1995).

For the reasons discussed above, health care does not work this way. Buyers and sellers are separated by layers of intermediaries who influence what is bought and sold as well as the price paid. Users of health care are seldom choosers of health care, and even less often bear the costs. Prices are simultaneously extravagant and muted. Government represents both the largest purchaser of health care and the most significant constraint on health care transactions, with its payment and regulatory functions seldom aligned. Some parts of health care are astonishingly innovative (e.g., how to keep preterm babies alive) while others are not (e.g., how to deal with a sprained ankle on a Sunday). And the American medical profession continues to cast its long shadow over the health care economy, cloaking the peculiarities of its basic economics in expertise and ethics.

Antitrust law and regulated industries are not strangers. Health care regulation is so layered and ingrained, however, that the most straightforward accommodations antitrust analysis makes to regulation – state action and implied repeal – are seldom available to guide enforcement. States seldom clearly articulate and actively supervise regulatory regimes that supplant competitive processes (all-payer rate setting and certificate of need laws being vestigial counterexamples), nor does Congress often deliberately substitute federal regulation for marketplace competition (patent protection for biomedical innovation being a counterexample). On balance, one would have to say that government policies in health care have tended to facilitate the acquisition and abuse of market power, but one would also have to say that this has been fortuitous rather than planned. Throughout the past century, moreover, government, the profession, and the public have all embraced the ideal of competition as appropriate for health care, even as they supported policies that undermined it. This is certainly the sentiment expressed in the Affordable Care Act, notwithstanding its alleged socialistic tendencies.

In practical terms, this state of affairs suggests a two-step approach to competition policy in health care as the US implements health care reform. The first step, which is explained in the remainder of this section, is to specify the most desirable dimensions for health care competition now and for the next several years. The second step, which is reserved for Section IV, is to connect those dimensions to antitrust doctrine and antitrust enforcement procedures.

C. “Cheaper, Quicker, More Reliable”

In the vast majority of sizeable markets for products or services, competition reduces price, increases timeliness of access or use, and improves reliability. Accordingly, achieving those three competitive goals are mainstays of industrial engineering. Health care markets, by contrast, have typically regarded such very ordinary objectives with disdain or embarrassment.⁷² Competition policy needs to overcome this resistance and restore normalcy to the first-pass criteria for what makes a product “better.”

Prices. Above all, sellers of health care need to compete on price. In the course of competition, prices should be known to individual buyers in advance (something that seems obvious but often is not the case for health care), should be transparent to buyers as a group, and should tend to the uniform (i.e., be less variable or discriminatory).

Safety and standardization. Beginning in the first round of widespread managed care in the 1990s, scholars and policymakers have worked energetically toward measurable, transparent quality of care. These efforts, while laudatory, largely presuppose a tradeoff between price and quality that has seldom characterized the health care system in operation. Quality metrics remain important to competitive (and noncompetitive) mechanisms for improving health outcomes, but taking the longer view it is hard to escape the conclusion that price competition is more

⁷² See, e.g., Susan Dentzer, *It’s Past Time to Get Serious About Transforming Care*, 32 HEALTH AFFAIRS 6, 6 (2013) (“One eternal mystery of US health care is why patients and payers have been loath to demand attributes they take for granted in other sectors of the economy, such as convenience, price transparency, and reasonable costs.”)

important. Quality is most practically incorporated into competition in terms of keeping patients safe while they receive care and ensuring that the care they receive meets standards for substance and process (and “warranting” additional cost if safety lapses or service delivery strays from the expected). Uncertainty is a fact in medicine, but evidence is compelling that more variability and injury in care arises from uncontrolled than from uncontrollable processes of care.

New entry. Quicker, cheaper, more reliable health care will only happen if new ideas constantly enter the market. Competition from unaccustomed sources is therefore to be encouraged. This means lowering barriers to entry, including regulatory and self-regulatory approval to treat (e.g., licensing rules, scope of professional practice restrictions, facility certification). It also means developing and enforcing standards for interoperability of systems, and reducing the cost of contracting between new and existing market participants.

D. Products that Work

Surprisingly, many health care services provided in this country do not meet patients’ needs. A recent report from the Institute of Medicine estimated annual waste in the health care system of \$750 billion.⁷³ This includes substantial amounts of overpriced and ineffective care. A premium for health care competition is to generate products and services that do people clear good and are priced accordingly.

Efficient Acute and Complex Care: A large amount of waste occurs within hospitals or in connection with the treatment of serious illness. The long history of cost-insensitive third-party payment has made health care facilities much more cognizant of their revenue streams than of their cost structures. These payment streams generally reward additional days or units of services regardless of demonstrated benefit. At the same time, production models for acute or

⁷³ BEST CARE AT LOWER COST, *supra* note 16.

complex, facility-based care typically place physicians in independent, loosely supervisory roles rather than as part of integrated and experienced teams.

Competition to provide these services needs to emphasize focused, reproducible care that is delivered in service units that correspond to patient benefit. For this reason, new delivery models typically contemplate the receipt of bundled, episodic payment. “Bundled” usually refers to a single payment that encompasses both the professional (physician) and facility (hospital) components of conventional “reimbursement” systems, thereby rewarding care in which individuals with complementary skills work together in technologically advanced practice settings. “Episodic” refers to payment not for each service, but for a sustained period of time, a full course of illness, or a definitive (and typically effective) treatment. The days of legally sanctioned but poorly planned and uncoordinated services “ordered” from hospitals by physicians acting as patients’ cost-insensitive purchasing agents should be behind us.

Community-based basic care and health promotion. Americans are far less healthy than our wealth suggests.⁷⁴ Basic medical care and health-protective services are seldom accessible even when they are affordable. Better delivery models would distribute these functions widely across communities and embed them in the daily, routine activities of people who need not be labeled as “patients” in order to be served. Compared to the acute care setting, the community setting also presents unexploited opportunities to allow consumer preferences and associated behaviors to evolve in a more healthful, lower-cost direction.

Consumer choice around acute and complex care probably requires more structure than at present, likely achieved through organized, insured payment. By contrast, choice of basic care

⁷⁴ ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT, OECD HEALTH DATA 2013: HOW DOES THE UNITED STATES COMPARE (Jun. 27, 2013), available at <http://www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf>; see also Barbara Starfield, *Is U.S. Health Really the Best in the World?*, 284 J. AM. MED. ASS’N 483, 483 (2000).

and health promotion should be more flexible, with a larger range of professional and non-professional skills and service setting, and with less insurance involved. Competition for these services therefore should promote personal engagement with health on the part of the consumer-patient (e.g., through cellphones) and less expensive, more accessible one-on-one care relationships.

Insurance that adds value. Health insurance is ubiquitous but the value it adds is increasingly in doubt. Underwriting risk has receded for the majority of health insurers, either because that function can be performed at lower cost by government (e.g., Medicare) and large employers or because laws such as the ACA limit insurers' actuarial role. Instead, much health insurance business is the provision of administrative services: managing enrollment, verifying eligibility, contracting with health care providers, and processing claims. In the future, health insurers must compete to offer discrete products with clear purposes, whether these consist of risk management, care coordination, price-brokering, health information stewardship, health promotion services or something else.

The unequal distribution of illness, its unpredictable timing, and the high cost of care make insurance an inevitable if not always beneficial attribute of the health care system. If conventional insurance recedes in importance as health care markets evolve under health reform, it will nevertheless be important to anticipate and address other ways in which the unequal distribution of illness may complicate competition. Examples include preventing profiteering in connection with urgent care or life-threatening illness, managing care for individuals with multiple chronic or complex conditions, and supporting reserve capacity so that day-to-day production decisions can be made with lean inventory and flexible staffing.

Even competition channeled into these directions will not fully address the needs of the health care system. For example, geographic dispersal of patient populations remains challenging whether in connection with sprawling suburbs and exurbs, for single-provider towns, or for provider-less rural areas. Other challenges arise from the need to fund access, charitably or otherwise, for patients who cannot afford service. Still others relate to individual medical services that may be compromised in the process of market restructuring, such as women's health care in consolidated markets dominated by Catholic health care providers. But products and services that do what they are supposed to do more quickly, cheaply, and reliably would be a substantial improvement.

IV. IMPLICATIONS FOR ANTITRUST ANALYSIS AND ENFORCEMENT IN HEALTH CARE

[This concluding section will survey the current doctrinal and practice landscape and offer suggestions for a more effective competition policy in health care. It will include discussion of how recent changes in the antitrust enforcement process may have perverse consequences for competition policy.]

A. Antitrust and regulation

- a. State action
- b. McCarran-Ferguson and other express/implied repeal
- c. Patent-antitrust interface
- d. *Trinko*, *Kartell* and regulatory effects on competition policy
- e. Regulation of health care skills, geography, quality, and payment

B. Investigation

- a. Triggers

- b. Third-party interviews
 - c. Economic models
- C. Litigation
 - a. Discovery
 - b. Third-party subpoenas
 - c. Expert witnesses
 - d. Private antitrust enforcement (facilitating and constraining doctrines)
- D. Identifying the market
 - a. The product (insurance, bundles, etc.)
 - b. The geography
 - c. Formal definition (for mergers, unilateral vs. coordinated effects analysis)
 - d. Identifying buyers and sellers
- E. The competitive process
 - a. Price and non-price competition (including constrained dimensions)
 - b. Bargaining (e.g., “must-haves,” tiering)
 - c. Information sharing, information restraint, and standardization
 - d. Horizontal and vertical agreements (inputs, scale, scope)
 - e. Efficiencies
- F. Concentration
 - a. Barriers to competitive entry
 - b. Exclusionary conduct (e.g., contracts referencing rivals)
 - c. Exclusivity and bottlenecks
 - d. Dominance and single-producer markets

e. Asset exit

G. Competition advocacy

a. Myths around price-quality tradeoffs

b. Industrial production rather than unfettered physician discretion

c. Health care as dynamic terrain of contestable markets

V. CONCLUSION [TO COME]

Allocative efficiency and productive efficiency in health care markets.

Dynamic efficiency (innovation)