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The Provider Monopoly Problem in Health Care

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ABSTRACT

Health care providers with market power enjoy substantially more pricing freedom than comparable monopolists in other markets, for a reason that is not generally recognized: U.S.-style health insurance.

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Monopoly in health care markets therefore has redistributive effects that are uniquely burdensome for consumers. Significant allocative inefficiencies—albeit not the kind usually associated with monopoly—also result, particularly when the monopolist is a nonprofit hospital. We first demonstrate the need for a more aggressive antitrust policy for the health sector, one that effectively prevents the creation of new provider market power through mergers, other alliances, or anticompetitive practices. An immediate need is to prevent the formation of “accountable care organizations” that integrate providers horizontally to achieve market power, not just vertically to achieve efficiency. Because it is unlikely that courts or agencies could undo past mergers that bestowed monopoly power on providers, we also suggest some strategies for contesting existing monopolies. One strategy is to apply antitrust rules against “tying” arrangements so purchasers can combat providers’ profit-enhancing practice of overcharging for large bundles of services instead of trying to exploit separately any monopolies they possess in various submarkets. Another strategy is to use antitrust or regulatory rules to prohibit anticompetitive provisions, such as “anti-steering” or “most-favored-nation” clauses, in provider-insurer contracts. The provider monopoly problem is severe enough that we cannot exclude the more radical alternative of regulating provider prices.

I

INTRODUCTION

Ever since the antitrust laws were first applied systematically in the health care sector in the mid-1970s, some judges and commentators have resisted giving the statutory policy of fostering competition its due effect in health care settings.¹ Between 1995 and

¹ See *infra* note 18. The Supreme Court has consistently overruled lower courts’ attempts to infer special antitrust exemptions or craft softer antitrust rules for health care providers. See *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 330–31 (1991) (explaining the standard for establishing the potential effect of hospital medical staff decisions on interstate commerce); *Patrick v. Burget*, 486 U.S. 94, 105 (1988) (rejecting state legislature’s encouragement of physician peer review in hospitals as a basis for exempting abuses from federal antitrust remedies); *Fed. Trade Comm’n v. Ind. Fed’n of Dentists*, 476 U.S. 447, 455–57 (1986) (upholding the adequacy of evidence to support the FTC’s finding that dentists’ agreement to deny insurers access to patients’ x-rays was anticompetitive, not procompetitive); *Arizona v. Maricopa Cnty. Med. Soc’y*, 457 U.S. 332, 353–55 (1982) (treating physicians’ collective agreements on maximum prices as unlawful partly because the claim of procompetitive effects was facially unconvincing); *Nat’l Geromedical Hosp. & Gerontology Ctr. v. Blue Cross of Kansas City*, 452 U.S. 378, 391–93 (1981) (rejecting the implied exemption for market-allocation agreements

2000, for example, antitrust enforcers encountered judicial resistance when challenging mergers of nonprofit hospitals and suffered a six-case losing streak in such cases in the federal courts.² Although most of those pro-merger decisions ostensibly turned on findings of fact (mostly in identifying a geographic market in which to estimate the merger's probable effects on competition), those findings were often so arbitrary as to signify judicial skepticism about the wisdom of applying antitrust law rigorously in hospital markets.³ Implicitly, and often explicitly, the judges seemed to harbor a belief that nonprofit hospitals either would not exercise or would put to good use any market power they might possess.⁴ Although the government has

brokered by health-planning agencies created under federal statute). *But see* Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756 (1999) (raising the FTC's burden of proof in finding anticompetitive collective action by health professionals). The last decision is critically examined in Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL. POL'Y & L. 939, 949–53 (2001). The antitrust movement in health care was triggered in part by the Supreme Court's rejection in 1975 of general antitrust immunity for the so-called "learned professions." *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 780, 791–93 (1975). *See generally* CARL F. AMERINGER, *THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION* (2008).

For a particularly egregious example of commentators' recommendations against applying antitrust law as written in health care markets, see John A. Norris & David S. Szabo, *Communication Between the Antitrust and the Health Law Bars: Appeals for More Effective Dialogue and a New Rule of Reason*, 7 AM. J.L. & MED. xi, xiii (1981) ("Before the courts attempt to coerce health care providers into more competitive modes of behavior, they should be reasonably certain that more competitive behavior not only is possible, but is desirable as well.").

² U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* ch. 4, at 1–2 n.7 (2004), available at http://www.justice.gov/atr/public/health_care/204694.pdf.

³ For discussions of these cases and of the general ambivalence toward competition in health care markets, see Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497 (2006); Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191 (1997); Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007).

⁴ The district judge in *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), was especially unambiguous in championing nonprofit hospitals as benign monopolists:

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

Id. at 1302. Likewise, the judge revealed a hostility to price competition between hospitals, remarking that "[i]n the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars." *Id.* The

more recently won back some of the legal ground thus lost,⁵ its inability over time to apply antitrust law rigorously and systematically in the big business that health care has become is one important—though not the only—reason why many health care markets are now dominated by firms with alarming pricing power.⁶

The purpose of this Article is to call attention to the fact that monopoly power in the hands not only of nonprofit hospitals but also of other providers or suppliers of health services or products is more, not just equally, harmful to both consumers and the general welfare than monopolies of other kinds. Therefore, we submit, mergers and consolidations and other potentially monopolistic practices of health care providers—including the very recent wave of consolidating market power around so-called accountable care organizations⁷—should be subject to special, not relaxed, vigilance by antitrust agencies and courts. Specifically, we observe (as, surprisingly, the antitrust agencies and economists generally have not⁸) that U.S.-style health insurance greatly enhances the pricing freedom of firms possessing market power in health care markets, resulting in much larger monopoly profits and much greater redistributions of wealth than would result from comparable monopoly power in markets where consumers face prices directly. Moreover, the combination of

Butterworth court was not alone in its predilections. A Missouri judge, reviewing a hospital merger challenged by the FTC, remarked to the federal agency, “I don’t think you’ve got any business being in here It looks to me like Washington, D.C. once again thinks they know better what’s going on in southwest Missouri. I think they ought to stay in D.C.” *Fed. Trade Comm’n v. Freeman Hosp.*, 69 F.3d 260, 263 (8th Cir. 1995) (quoting district court hearing).

⁵ See *infra* notes 19–22 and accompanying text.

⁶ For surveys of how hospital consolidations have increased hospital prices, see Gloria J. Bazzoli et al., *Hospital Reorganization and Restructuring Achieved Through Merger*, 27 HEALTH CARE MGMT. REV. 7 (2002); Martin Gaynor, *Competition and Quality in Health Care Markets*, 2 FOUNDS. & TRENDS IN MICROECON. 441 (2006); CLAUDIA H. WILLIAMS ET AL., ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (2006), available at www.rwjf.org/files/research/no9policybrief.pdf; see also WILLIAM B. VOGT, NAT’L INST. FOR HEALTH CARE MGMT. FOUND., HOSPITAL MARKET CONSOLIDATION: TRENDS AND CONSEQUENCES (2009), available at http://nihcm.org/pdf/EV-Vogt_FINAL.pdf (documenting the extent of provider market concentration among hospitals & other providers).

⁷ The special problem presented by these entities, provided for in sections 3022 and 10307 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), is discussed *infra* notes 73–84 and accompanying text. See generally Robert Pear, *Consumer Risks Feared as Health Law Spurs Mergers*, N.Y. TIMES, Nov. 20, 2010, <http://www.nytimes.com/2010/11/21/health/policy/21health.html>.

⁸ See *infra* notes 50–51.

health insurance and monopoly, together with other special features of the health care marketplace, also fosters serious inefficiency in the allocation of resources—albeit not the kind of misallocation that economic theory normally associates with the exercise of monopoly power.⁹ In our view, lawyers and economists wrangling over whether nonprofit hospitals or other health care entities behave badly when in possession of market power¹⁰ have missed the most important points. The case for a rigorous competition policy in the health care sector is significantly stronger, we claim, than even its advocates have generally appreciated.

If anything, the major health care reform legislation enacted by Congress in 2010¹¹ makes even more imperative a strong antimonopoly policy in health care. Designed principally to extend generous private health coverage to millions of currently uninsured persons,¹² the Patient Protection and Affordable Care Act (PPACA) does little to address the monopoly problem. On the contrary, despite the immense implications for the nation's precarious economic future of the new rights, entitlements, and subsidies it embodies, the PPACA seems certain to add substantially to providers' and suppliers' profits.¹³ Yet its potential to further enrich industry monopolists went

⁹ For a more detailed and documented exposition of our observation that U.S.-style health insurance inflates the various costs of monopoly in health care markets, see Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 13–31.

¹⁰ See U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 2, ch. 4, at 29–33 (citing cases and commentary on the significance of hospitals' nonprofit versus for-profit status).

¹¹ PPACA, Pub. L. No. 111-148, 124 Stat. 119.

¹² Ironically, these individuals' previous lack of such insurance long provided a plausible justification for not requiring nonprofit hospitals to face effective price competition; only by generating extraordinary surpluses, many believed, could such hospitals cover the uncompensated costs of treating the uninsured. See *infra* notes 34–40 and accompanying text. The irony is that the legislation, while reducing providers' need to dispense such charity, will leave in place the monopolies previously tolerated largely because of the alleged need to generate charitable resources.

A further irony emerges from empirical evidence suggesting that hospitals able to exercise market power—and thus able to generate large surpluses in treating privately insured patients—allow their overall costs to rise to a point where they lose money treating Medicare patients. Jeffrey Stensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFF. 1045 (2010). In other words, the conventional wisdom that high uncompensated care costs cause cost shifting and higher charges to private payers has it at least somewhat backward.

¹³ Most significantly, the new law's encouragement of accountable care organizations is likely to increase providers' pricing freedom and is already having adverse effects on competition. See *supra* note 7. In addition, section 1001 of the PPACA adds section

largely undiscussed in the debates preceding its enactment.¹⁴ Democrats, who might normally be expected to object to monopoly's redistributive consequences, mostly avoided the issue because they feared losing industry support for their symbolically important reform project.¹⁵ Republicans, though decrying the proposed bill's potential costs to consumers and taxpayers, were unspecific about its potential for overpaying providers, a political constituency that they, like the Democrats, were reluctant to offend. Regrettably, the resulting legislation may give the nation the worst of both worlds: on the one hand, an insurance market lacking the incentives and room for competitive innovations that are essential if insurers are to counteract powerful cost drivers and, on the other hand, regulatory mechanisms incapable of compensating effectively and sensitively for the absence of reliable market forces.¹⁶ Unless an effective competition policy (or some workable alternative) can be implemented in the health sector, many millions of additional persons will soon be forced to carry

2718(a) to the Public Health Service Act, which mandates that insurers maintain high medical-loss ratios (that is, incur low administrative costs), thereby possibly limiting what insurers will be able to do administratively to contest providers' market power and otherwise curb the cost-increasing effects of moral hazard associated with open-ended health coverage. See *infra* notes 54–55 and accompanying text (observing that uncontested moral hazard ultimately explains the extraordinary profitability of provider and supplier monopolies in health care).

¹⁴ A recent examination of California markets documents "providers' growing market power to negotiate higher payment rates from private insurers," calling it "'the elephant in the room' that is rarely mentioned." Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 699 (2010). For dramatic evidence of increased provider market power in Massachusetts (an early adopter of health reform that served as a model for the federal effort), see *infra* notes 28–33 and accompanying text.

¹⁵ President Obama's cultivation of provider support for the Democrats' bill was apparent at a speech where he appeared in the White House East Room with numerous physicians in white coats both on stage and in the audience. See President Barack Obama, *Moving Forward on Health Care Reform* (Mar. 3, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-health-care-reform>.

¹⁶ For early warnings, directed principally to conservatives, about the unworkability of a private market for health care absent major reforms of tax and legal policy, see Clark C. Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in MARKET REFORMS IN HEALTH CARE: CURRENT ISSUES, NEW DIRECTIONS, STRATEGIC DECISIONS 22 (Jack A. Meyer ed., 1983); Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 87 (Robert B. Helms ed., 1993). For an account of failed efforts to create a responsible, market-driven health care system, including a discussion of how regulatory politics disserve ordinary Americans, see Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 55.

exactly the kind of health coverage that currently serves provider and supplier monopolists so well.

Most of this Article develops new insights that should cause antitrust enforcers and courts or other regulators to scrutinize future health-sector mergers, the creation of accountable care organizations, and providers' other potentially monopolistic practices with special skepticism, thus preventing further market concentration. However, because consumer welfare also requires that existing concentration be reduced and competition intensified in markets for provider services, we conclude by briefly considering how deconcentration and the restoration of price competition might occur. In the belief that payers could do more to circumvent and thereby weaken specific provider monopolies, we suggest how antitrust agencies, courts, and regulators with authority over insurers' contracts with providers and consumers might facilitate the emergence of effective price competition in concentrated markets. Monopolies might be overcome, for example, by rigorously applying antitrust principles or otherwise enabling private payers to negotiate more competitive prices for specific provider services. Our discussion is meant to induce hope that the pricing freedom of health-sector monopolies can be significantly reduced by payers facing strong competitive pressures to control costs and reduce premiums. We would be less hopeful and enthusiastic about second-best, inevitably politicized strategies, such as imposing price regulation or empowering a single public payer to dictate provider prices.

This Article uses the hitherto underappreciated dangers of letting nonprofit hospitals attain and exercise market power to illustrate the larger provider monopoly problem facing today's insurers, consumers, and policy makers. Our arguments also apply, however, to providers and suppliers of other kinds.¹⁷

¹⁷ For a discussion of how, for example, pharmaceutical companies similarly exploit monopoly power in health care markets, with price and efficiency consequences more severe than those usually associated with monopoly, see Havighurst & Richman, *supra* note 9, at 24–28 (discussing how U.S.-style health insurance magnifies drug company profits and distorts innovation incentives).

II

SHOULD NONPROFIT PROVIDERS BE ENTRUSTED WITH MARKET
POWER?

The monopoly problem in health care markets is much greater today because too many judges and commentators have chosen to deem competition as inappropriate in health care or to view nonprofit hospitals as benign servers of the public interest rather than as potential monopolists against whom consumers need antitrust protection.¹⁸ Specifically, antitrust agencies have found it difficult to convince courts both that nonprofit community hospitals would be likely to use any market power they achieve to raise prices and that, if they did, it would necessarily be a bad thing.

A. *Pricing Practices*

In 2007, the Federal Trade Commission (FTC), in a case challenging a merger of nonprofit hospitals on Chicago's North Shore, found convincing proof that, following the merger, the new entity had substantially raised prices for managed-care organizations.¹⁹ The case was unusual because, rather than

¹⁸ Whatever one's prior beliefs about the merits of competition in health care, the antitrust laws are the law of the land and should be applied by courts without second-guessing the deep-rooted statutory policy of maintaining competitive markets. Indeed, in 1898, then Circuit Judge William Howard Taft famously warned against relying on "the vague and varying opinion of judges as to how much, on principles of political economy, men ought to be allowed to restrain competition." *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 283 (6th Cir. 1898). Compare *id. with Norris & Szabo*, *supra* note 1. For a nonlawyer's observation that those who endorse enforcement of the antitrust laws in medical markets often sound like members of "a religious cult," see Mark Schlesinger, *Markets as Belief Systems and Those Who Keep the Faith*, 31 J. HEALTH POL. POL'Y & L. 417, 420 (2006). To be sure, antitrust experts who criticized the line of cases allowing mergers of nonprofit hospitals often indicated their own conviction that allowing monopoly in hospital markets would harm, not benefit, consumers. See *supra* note 3. But those who question antitrust enforcement in the health sector because of their own policy assumptions or preferences are subversive in a way that those who advocate rigorous enforcement of laws already on the books are not. In any case, even if antimonopoly efforts in health care must be defended on policy (and not just legal) grounds, it is irrelevant whether in theory or in fact competition can or cannot, either under current circumstances or with appropriate reforms, yield socially optimal results in the health care sector. In a hospital merger case, for example, it should be enough that "monopoly power is worse than the alternative" and that "monopoly harms health care consumers just [as] it harms the consumers of conventional products." Gaynor, *supra* note 3 at 502, 504. Our argument, of course, is that monopoly is unusually, not just ordinarily, harmful to consumers of health care.

¹⁹ *Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *53 (F.T.C. 2007).

intervening to stop the acquisition when it was first proposed, the FTC initiated its challenge four years after the merger was consummated. Bringing the case at that stage accomplished two things: First, it made it unnecessary for the FTC to seek a preliminary injunction against the merger in federal court—where antitrust enforcers had lost the six previous cases. Second, challenging a completed merger gave the FTC's staff an opportunity to demonstrate in fact, and not just in theory, that nonprofit hospitals gaining new market power will use it to increase prices. The direct proof obtained in the *Evanston Northwestern* case makes it unlikely that future federal courts will allow the consummation of mergers of nonprofit hospitals under the illusion that such mergers do not have the usual anticompetitive effects.

The FTC's findings in *Evanston Northwestern* also discredited expert economic testimony that an earlier court had cited prominently in approving a hospital merger in Grand Rapids, Michigan.²⁰ That testimony rested on empirical research purporting to show that, in concentrated markets, nonprofit hospitals generally had lower prices than corresponding for-profit hospitals.²¹ Although that research was effectively discredited in later economic studies,²² the facts found in *Evanston Northwestern* should finally put to rest the notion that nonprofit hospitals are immune from the temptation to raise prices when they are in a position to do so.²³

Evanston Northwestern's findings also undercut the common belief that community leaders on a nonprofit hospital's governing board are vigilant about health care costs. The judge in the Grand Rapids case

²⁰ Fed. Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285, 1303 (W.D. Mich. 1996).

²¹ *Id.* at 1297 (citing an expert's "findings suggest[ing] that a substantial increase in market concentration among nonprofit hospitals is not likely to result in price increases"). The expert cited by the court, William J. Lynk, reached the same conclusion in scholarly articles. William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 459 (1995); William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363, 377 (1994).

²² See U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 2, ch. 4, at 33 (concluding "the best available evidence indicates that nonprofits exploit market power when given the opportunity to do so"); David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87 (1999); Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69 (1999).

²³ Even if such hospitals do not *maximize* their profits (as for-profit firms are generally assumed to do), health insurance confers on them so much pricing freedom (*see infra* Part III) that any self-restraint they may show is virtually beside the point.

permitted the merger in part because the chairmen of the two hospitals' boards each represented a large local employer and "testified convincingly that the proposed merger [was] motivated by a common desire to lower health care costs."²⁴ In this same vein, a proponent of another hospital merger in 2007 gave assurance that allowing the merger would not cause health insurance premiums to increase because several hospital "board members . . . are employers who worry about the cost of health-care."²⁵ Economists generally agree, however, that employees themselves, not employers, ultimately bear the cost of their own health coverage in reduced wages or other fringe benefits.²⁶ To be sure, employers are never happy to pay higher insurance premiums and would prefer to increase their employees' compensation in more visible ways. But they are ultimately committing their workers' money, not their own (or their shareholders'), in hospital boardrooms. Moreover, nonprofit hospitals have few legal or institutional reasons to engage in only progressive redistribution.²⁷ In general, community leaders on nonprofit hospital boards have little incentive to resist any hospital project that seems good for the community if it can be financed from the hospital's reserves and future surpluses.

A recent report by the Massachusetts Attorney General documents how nonprofit hospitals in Massachusetts have aggressively exploited their market power, even when health care costs were strangling public and private budgets.²⁸ Following Massachusetts's passage of the nation's first legislative effort to achieve universal health

²⁴ *Butterworth*, 946 F. Supp. at 1297.

²⁵ Felice J. Freyer, *Hospital Merger Reaction Cautious*, PROVIDENCE J., July 29, 2007, http://www.projo.com/news/content/HOSPITAL_FOLO_07-29-07_KS6HQED.32ff750.html (describing the proposed merger of Rhode Island's two largest hospital systems); see also *Fed. Trade Comm'n v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995) ("[I]f a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level even if it has the power to do so.").

²⁶ See generally Jonathan Gruber, *Health Insurance and the Labor Market* (Nat'l Bureau of Econ. Research, Working Paper No. 6762, 1998) (reviewing the empirical literature and finding "a fairly uniform result: the costs of health insurance are fully shifted to wages").

²⁷ See *infra* notes 35–39 and accompanying text; see also Timothy Greaney & Kathleen Boozang, *Mission, Market and Trust in the Nonprofit Healthcare Enterprise*, 5 YALE J. HEALTH POL'Y L. & ETHICS 1 (2005); Havighurst & Richman, *supra* note 9, at 22–24.

²⁸ OFFICE OF MASS. ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(b) (2010), available at http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf [hereinafter HEALTH CARE COST TRENDS].

coverage, the state legislature directed the Attorney General to analyze the causes of rising health care costs. The resulting report concluded that prices for health services are uncorrelated with either quality or costs of care but instead are positively correlated with provider market power.²⁹ The report further observed that prominent nonprofit medical centers—specifically, the Massachusetts General Hospital and Brigham and Women’s Hospital, which had merged in 1993 to create Partners HealthCare—were most responsible for leveraging their market and reputational power to extract high prices from insurers.³⁰ Reporting by *The Boston Globe* had previously shown the surprising extent to which Partners was able to extract extraordinary prices in agreements with presumably cost-conscious insurers.³¹ For example, when some insurers, such as the Tufts Health Plan, resisted Partners’ demands for price increases and tried to assemble networks with Boston’s other hospitals, Partners launched an aggressive marketing campaign that triggered threats by many of Tufts’ corporate customers to switch insurers.³² Later discussion remarks on the monopolistic, price-increasing effects of certain anticompetitive provisions insisted on by Partners in its contracts with insurers.³³

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

²⁹ *Id.* at 16–33.

³⁰ *Id.* at 29–30.

³¹ *A Handshake That Made Healthcare History*, BOS. GLOBE, Dec. 28, 2008; *Spotlight: Unhealthy System*, BOS. GLOBE, Dec. 28, 2008, http://www.boston.com/news/specials/healthcare_spotlight/; *Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs*, BOS. GLOBE, Dec. 21, 2008; *A Healthcare System Badly Out of Balance*, BOS. GLOBE, Nov. 16, 2008.

³² *A Handshake That Made Healthcare History*, *supra* note 31 (describing the “humiliation” experienced by the Tufts Health Plan’s CEO as he caved to Partners’ price demands and “became an object lesson for other insurers, a lesson they would not soon forget [as the] balance of power had shifted” to Partners). In Orlando, insurer United Healthcare experienced similar threats as it resisted a request for a sixty-three percent price increase by the region’s leading nonprofit hospital chain. Linda Shrieves, *Florida Hospital-United Healthcare Face-Off Spurs Fear, Anger*, ORLANDO SENTINEL, Aug. 6, 2010, http://articles.orlandosentinel.com/2010-08-06/business/os-insurance-negotiations-20100806_1_switch-doctors-new-doctors-county-employees.

³³ *See infra* notes 91–96.

B. Charitable Activities

Federal judges may have tolerated mergers conferring new market power on nonprofit hospitals less because they thought the hospitals would not exercise that power than because such hospitals seemed to differ from conventional monopolists in ways that should lessen social concern about their enrichment. Specifically, nonprofit, tax-exempt hospitals are required by their charters and the federal tax code to retain their profits and use them only for “charitable” purposes. Thus, if one could assume that the redistributions of wealth resulting from the exercise of market power by nonprofit hospitals run generally from richer to poorer rather than in the opposite direction, there would be at least an argument for viewing nonprofit hospital monopolies as benign for antitrust purposes. Although such an argument would be based on a questionable reading of the antitrust statutes, one widely noted case allowed prestigious universities to act anti-competitively in order to direct their limited scholarship funds toward lower-income students.³⁴ One easily senses in hospital merger cases a similar judicial dispensation in favor of nonprofit enterprises that combine for seemingly progressive purposes.³⁵

But however antitrust doctrine views (or should view) monopolies dedicated to progressive pursuits, it is far from clear that nonprofit hospitals reliably use their dominant market positions to redistribute wealth only in progressive directions. The Internal Revenue Code’s charitable-purposes requirement has been interpreted very broadly, allowing such hospitals to spend their untaxed surpluses on anything that arguably “promotes health.”³⁶ This includes much more than just caring for the indigent. Indeed, many exempt hospitals are located in areas that need relatively little in the way of truly charitable care, either because the community is relatively affluent and its population

³⁴ *United States v. Brown Univ.*, 5 F.3d 658, 678–79 (3d Cir. 1993). Reading this ruling as an endorsement of the universities’ redirection of scholarship funds to needier students would at least limit substantially (and prudently) the kind of worthy purpose a cartel of nonprofit entities may offer as an antitrust defense. *See supra* note 18 (citing *Addyston Pipe*’s warning against judicial discretion, including the consideration of worthy-purpose defenses, in applying antitrust law).

³⁵ *See, e.g., supra* note 4.

³⁶ Rev. Rul. 69-545, 1969-2 C.B. 117. Ironically, this controversial ruling, relaxing an earlier requirement that an exempt hospital “must be operated to the extent of its financial ability for those not able to pay for the services rendered,” Rev. Rul. 56-185, 1956-1 C.B. 202, came at a time when the Medicare and Medicaid programs were relatively new and private health insurance was expanding, all seemingly reducing the need for nonprofit hospitals to be charitable in the original sense.

well insured or because a public hospital assumes most of the charity burden. Moreover, although all hospitals inevitably subsidize the treatment of some uninsured patients, many of today's uninsured are members of the middle class and not obvious candidates for subsidies from the insured population.³⁷ Finally, federal, state, and local governments separately and substantially subsidize nonprofit hospitals' most clearly charitable activities, both through special tax exemptions and relief and by direct subventions; such activities therefore should not count significantly in estimating the net direction of redistributions effected by hospitals through the exercise of newly acquired market power.

Thus, true charity has in recent years accounted for only a relatively small fraction of what nonprofit hospitals do in return for their federal tax exemptions. Indeed, such hospitals can usually qualify for exemption merely by spending their surpluses on medical research, on training various types of health care personnel, and, most importantly, on acquiring state-of-the-art facilities and equipment, which (ironically) can also secure and enhance their market dominance.³⁸ Many of these activities confer significant benefits on interests and individuals relatively high on the income scale.³⁹ To be

³⁷ Supplemental census data from 2007 showed that nearly thirty-eight percent of America's uninsured come from households with over \$50,000 in annual income and nearly twenty percent from households with over \$75,000. See CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 21 tbl.6 (2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf>. Implementation of the PPACA will greatly reduce hospitals' charity burdens, leaving undocumented immigrants as the principal category of the uninsured.

³⁸ See *infra* notes 55–56 and accompanying text. On Partners HealthCare's use of its surpluses to build new and better facilities and expand into new markets, thereby securing additional market power, see *Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs*, *supra* note 31.

Not only does tax exemption create opportunities for dominant firms to increase their dominance, but a nonprofit firm lacking such dominance may be ineligible for exemption—and thus at a severe competitive disadvantage—precisely because it faces competition and therefore lacks the discretionary funds necessary to demonstrate how it “benefits the community.” Tax policy thus rewards, fosters, and protects provider monopoly, ensuring only that monopoly profits, however large, are not put to objectionable, non-health-related uses. Cf. *Geisinger Health Plan v. Comm’r*, 985 F.2d 1210, 1214 (3d Cir. 1993) (denying tax exemption to a nonprofit health plan because it did not provide direct health services and because, despite planned subsidies for low-income subscribers, it had “been unable to support the program with operating funds because it operated at a loss from its inception”).

³⁹ Many physicians, for example, benefit handsomely, first, from the valuable training hospitals provide and, later, from using expensive hospital facilities and equipment at no direct cost to themselves. The tax authorities regard such “private benefits” as merely

sure, most of the activities and projects financed from hospital surpluses are hard to criticize in the abstract. But many of them are not so obviously progressive in their redistributive effects (or otherwise so obviously worthy of public support) that antitrust prohibitions should be relaxed so hospitals can finance more of them.

In any case, financing hospital activities and projects of any kind from hospitals' monopoly profits causes their costs to fall ultimately and more or less equally on individuals bearing the cost of health insurance premiums. The incidence of this financial burden thus closely resembles that of a "head tax"—that is, a tax levied equally on individuals regardless of their income or ability to pay. Few methods of public finance are more unfair (regressive) than this. Those who take a benign view of the seemingly good works of health care providers should focus more attention on who (ultimately) pays for and who benefits from those nominally charitable activities.⁴⁰

The regressive redistributive effects of nonprofit hospitals' monopolies appear never to have been given due weight in antitrust appraisals of hospital mergers.⁴¹ To be sure, pure economic theory withholds judgment on the rightness or wrongness of redistributing income because economists have no objective basis for preferring one distribution of wealth over another. But the antitrust laws enjoy general political support principally because the consuming public resents the idea of illegitimate monopolists enriching themselves at their expense.⁴² This is why mergers of all kinds are suspect in the

"incidental" to the hospitals' larger purpose of promoting the health of the community. See I.R.S. Gen. Couns. Mem. 39,862 (Dec. 2, 1991).

In our view, some private benefit is present in all typical hospital-physician relationships Though the private benefit is compounded in the case of certain specialists, such as heart transplant surgeons, who depend heavily on highly specialized hospital facilities, that fact alone will not make the private benefit more than incidental.

Id.

⁴⁰ See generally Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 1; Havighurst & Richman, *supra* note 9.

⁴¹ Under reasonable assumptions, a hospital merger creating new market power would raise insurance premiums by roughly three percent, increasing the "head tax" on the median insured family by roughly \$400 per year, hardly a trivial amount. In addition, according to one estimate, hospital mergers in the 1990s caused nearly 700,000 Americans to lose their private health insurance. Robert Town et al., *The Welfare Consequences of Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 12,244, 2006).

⁴² HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE 50 (3d ed. 2005) ("[S]tatements [made during debates] may suggest that the primary intent of the Sherman Act's framer was not economic efficiency at all, but

eyes of antitrust enforcers; they may be an easy and unjustified shortcut to gaining market power. Although proponents of consolidations increasing concentration in provider markets usually tout efficiencies they expect to achieve by combining and rationalizing operations, the opportunity to increase their bargaining power vis-à-vis private payers is the likelier explanation for all such mergers in concentrated markets.⁴³ In any event, the ubiquity of nonprofit hospitals with market power now constitutes a significant source of the provider monopoly problem in health care.

III

HOW HEALTH INSURANCE COMPOUNDS THE HARMS OF PROVIDER MONOPOLY

In economic theory, monopoly is objectionable because the higher prices it enables a seller to charge cause some consumers who would happily pay the competitive price to forgo enjoyment of the monopolized good or service, thus diverting scarce resources to less-valued uses and reducing aggregate welfare. Fortunately, such output- and welfare-reducing (misallocative) effects are greatly lessened in health care markets because the large number of patients with health insurance can easily pay provider monopolists' asking prices for desirable goods or services rather than being induced to forgo their consumption.⁴⁴ Unfortunately, however, health insurance

rather the distributive goal of preventing monopolists from transferring wealth away from consumers.”).

⁴³ See DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE* 122 (2000) (“I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.”); see also Berenson et al., *supra* note 14, at 704 (quoting a local physician as saying, “Why are those hospitals and physicians [integrating]? It wasn’t for increased coordination of care, disease management, blah, blah, blah—that was not the primary reason. They wanted more money and market share.”). For more particular reasons to discount efficiency claims in evaluating health-sector mergers, see *infra* note 66.

⁴⁴ To the extent that uninsured patients cannot pay hospitals’ high prices, monopoly still causes allocative inefficiency of the usual kind (not to mention its adverse consequences for patients’ health). But many uninsured are treated free of charge or at reduced rates—an instance of price discrimination somewhat ameliorating monopoly’s usual misallocative tendency. Although providers’ pricing freedom certainly harms many lacking health insurance coverage, the principal emphasis here is on the combined effects of insurance and monopoly on both those with coverage and the economy as a whole. Because the PPACA is intended to increase the number of consumers with coverage, it seems certain to increase the redistributive consequences of health-sector monopolies.

has other, possibly more severe consequences because it both amplifies the redistributive effects of provider/supplier monopolies and contributes to allocative inefficiency of a different and arguably more serious kind. It is mainly to highlight the adverse, synergistic effects of combining health insurance and monopoly that we have written this Article.

A. *Redistribution of Wealth*

At the same time that health insurance ameliorates monopoly's usual adverse effects on output and allocative efficiency, it greatly exacerbates monopoly's other objectionable effect, the redistribution of wealth from consumers to powerful firms.⁴⁵ In the textbook model, the monopolist's higher price enables it to capture for itself much of the welfare gain, or "surplus," that consumers would have enjoyed if they had been able to purchase the valued good or service at a low, competitive price. In health care, insurance puts the monopolist in an even stronger position by greatly weakening the constraint on its pricing freedom ordinarily imposed by the limits of consumers' willingness or ability to pay. This effect appears in theory as a steepening of the demand curve for the monopolized good or service. The extraordinary profits that health insurance makes available to powerful sellers are earned mostly at the expense not of direct purchasers—insurers or patients—but of consumers bearing the cost of insurance.

Even under orthodox theory, therefore, health insurance enables a monopolist of a covered service to charge substantially more than the textbook "monopoly price,"⁴⁶ thus earning even more than the usual "monopoly profit." As serious as this added redistributive effect may be in theory, however, it is rendered even more serious in practice by certain deficiencies in the design and administration of real-world health insurance. For legal, regulatory, and other reasons, health

⁴⁵ See Havighurst & Richman, *supra* note 9, at 13–31.

⁴⁶ It is artificial (but not inaccurate) to speak of a hospital's "price" for a monopolized service because hospitals and private payers typically do not negotiate prices service-by-service but instead agree on a standard discount from the hospital's (uniformly high) list prices or on a standard markup from cost-related Medicare allowances. See Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 50 (2006). The amount of the discount will be less, or the markup more, however, to whatever extent the hospital enjoys market power over individual services. In practice, a purchaser cannot easily refuse to deal with a hospital or any other provider that possesses a monopoly over any significant service. See *infra* notes 86–91 and accompanying text. *But see infra* note 49.

insurers in the United States are in no position (as consumers themselves would be) to refuse to pay a provider's high price whenever it appears to exceed the service's likely value to the patient. Instead, insurers are bound by both deep-rooted convention and their contracts with subscribers to pay for any service that is deemed advantageous (and termed "medically necessary") for the patient's health, whatever that service may cost.⁴⁷ Consequently, available "close substitutes" for a provider's services do not check its market power as they ordinarily would do. Indeed, putting aside the modest effects of cost sharing on patients' choices,⁴⁸ the only substitute treatments or services that insured patients will accept are those they regard as perfect ones.⁴⁹ Unlike the situation when an ordinary

⁴⁷ See *infra* notes 54–55 and accompanying text. Although it is possible to imagine a contract that authorizes a health plan to compare benefits and costs in administering its coverage (in order to give its members only what they collectively deem it economical to pay for), the practical, legal, and political difficulties that insurers would encounter in thus rationing their coverage have generally precluded the use of such contracts in the U.S. market. See also CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* (1995). See generally Mark V. Pauly, *Competition and New Technology*, 24 *HEALTH AFF.* 1523 (2005) (recognizing, as few economists have, the importance of the practical inability of consumers to purchase health insurance that provides only selective coverage of costly technology). Indeed, even when managed care was in the ascendant in the 1990s, health plans did not undertake to ration their coverage on the basis of benefit/cost comparisons. The inability of insurers to control costs optimally as agents of their insureds results not only from the difficulty of writing, administering, and enforcing the requisite contracts but also from the tax system's exclusion of employer payments for health coverage from their employees' taxable income; with employers paying most of the premium, workers have been unaware of the true cost of their coverage to themselves and thus unduly resistant to cost-saving measures. See *supra* note 26 and accompanying text.

⁴⁸ Although cost sharing's low administrative costs and relatively non-controversial nature make it the mechanism of choice for rationing health coverage (to offset moral hazard), it may operate unfairly in insured groups comprising individuals with differing incomes. For discussion of the hypothesis that cost sharing unfairly enables those patients who are better able to pay the up-front charge to obtain disproportionate access to the premium pool, see Havighurst & Richman, *supra* note 9, at 41–49.

⁴⁹ Patients' hesitancy to accept lower-cost substitutes for top-shelf services or products is partly a result of the usual market failures associated with the provision of health services, particularly patients' difficulty in evaluating the quality of or necessity for particular care and the agency problems that arise from patients' inevitable reliance on physician advice rarely influenced by patient or insurer cost or price concerns. These factors explain how a provider with market power can charge dramatically higher prices for services that are similarly offered by other providers in the same market. See PAUL B. GINSBURG, *CTR. FOR STUDYING HEALTH SYS. CHANGE, RESEARCH BRIEF NO. 16: WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER* (2010), available at <http://www.hschange.com/CONTENT/1162/1162.pdf>. These factors also explain the phenomenon of "must-have" providers, especially hospitals, which consumers insist on having in their insurer's provider networks regardless

monopolist sells directly to cost-conscious consumers, the rewards to a monopolist selling goods or services purchased through health insurance may easily and substantially exceed the aggregate consumer surplus that patients would derive at competitive prices.

Discussions of antitrust issues in the health care sector rarely, if ever, explicitly observe how health insurance in general or U.S.-style insurance in particular enhances the ability of dominant sellers to exploit consumers.⁵⁰ Most notably, the special redistributive effects of monopoly in health care markets are not mentioned in the antitrust agencies' definitive statements of enforcement policy in the health care sector.⁵¹ Yet the effect we identify has potentially huge implications for consumers and the general welfare. Antitrust analysis of hospital mergers—as well as of other actions and practices that enhance provider or supplier market power—must therefore explicitly recognize the impact of insurance on health care markets. The nation will find it far harder—perhaps literally impossible—to afford the PPACA's impending extension of generous health coverage to additional millions of consumers if monopolists of health care services and products can continue to charge not what “the market” but what insurers will bear.

of the adequacy of less expensive alternatives. In these cases, reputational advantages, whether deserved or not, translate into providers' extraordinary pricing freedom. *See, e.g.*, Berenson et al., *supra* note 14, at 702 (identifying “must-have” hospitals in California markets); *supra* notes 31–32 and accompanying text.

⁵⁰ *But see* Havighurst & Richman, *supra* note 9, at 13–31. Economists have (only belatedly, it seems) recognized the effects of health insurance on the value of patent monopolies in the health sector, with particular reference to possible effects on innovation incentives. *See* Alan M. Garber et al., *Insurance and Incentives for Medical Innovation* (Nat'l Bureau of Econ. Research, Working Paper No. 12,080, 2006) (citing the possibility that innovation incentives might be excessive); Darius Lakdawalla & Neeraj Sood, *Insurance and Innovation in Health Care Markets* (Nat'l Bureau of Econ. Research, Working Paper No. 11,602, 2005) (suggesting how, under certain assumptions, innovation incentives might be optimal). For a recent demonstration that “[m]arket power in the health care market is . . . exacerbated by the feedback into insurance demand, leading to high health care prices,” *see* Rhema Vaithianathan, *Health Insurance and Imperfect Competition in the Health Care Market*, 25 J. HEALTH ECON. 1193, 1194 (2006). The last article, however, seems not to incorporate insights from the way health insurers actually purchase services (e.g., by selectively contracting with providers) or the handicaps under which they operate in counteracting moral hazard. *See infra* notes 54–55 and accompanying text.

⁵¹ U.S. DEP'T OF JUSTICE & U.S. FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 8–11 (1996), *available at* <http://www.justice.gov/atr/public/guidelines/1791.pdf>; *see also* U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 2.

B. Misallocative Consequences

Allowing nonprofit hospitals or other providers to gain market power by merger not only causes extraordinary redistributions of wealth but also contributes to inefficiency in the allocation of resources. In ironic contrast to the output restrictions associated with monopoly in economic theory, however, the misallocative effects cited here mostly involve the production and consumption of too much (rather than too little) of a generally good thing.⁵² As we show briefly here, these misallocations are both theoretically and practically important, and they provide still another new reason for special antitrust and other vigilance against providers' monopolistic practices, particularly including anticompetitive mergers and consolidations and powerful joint ventures.⁵³

⁵² *But see supra* note 44.

⁵³ Allocative efficiency is sometimes questioned as a theoretical justification for antitrust policy because of the so-called "problem of second best." This technical objection to the promotion of competition originates in the observation that factors such as lawful and unlawful monopoly, regulation, trade barriers, and taxes cause many goods and services throughout the economy to be priced in excess of the marginal costs of producing them, making it hard to maintain that intensifying price competition in any given market will necessarily improve overall resource allocation. The second best issue seems to be taken most seriously by those skeptical about relatively free markets. *See, e.g.*, Schlesinger, *supra* note 18 (raising this objection to competition in health care but confusing it somewhat with externality problems that arise because certain costs and benefits are not borne or captured by the parties to private transactions); Lawrence A. Sullivan, Book Review, 75 COLUM. L. REV. 1214, 1221 (1975) (reviewing MILTON HANDLER ET AL., TRADE REGULATION, CASES AND MATERIALS (1974)) (citing the second best problem as a predicate for stating "the emperor efficiency is stark naked"). Market-oriented scholars, it seems, barely acknowledge this challenge to their preferred paradigm because they sense that the most important distortions giving rise to the second best problem reflect misguided regulatory and other actions by government itself; market advocates might reasonably resent their opponents' use of government-created market failures to justify an even bigger role for government in managing the economy. Even so, the second best objection has forced economists to find other, less technical reasons for preferring competition to monopoly. Third-best arguments for competition include dispersion of economic power and its encouragement of productive efficiency, quality, and innovation.

Most notably, the problem of second best strengthens rather than weakens the case for fostering price competition in a market where, as with insured health care, goods and services are effectively underpriced to consumers. Thus, to the extent that the second best problem is that many goods and services are overpriced relative to their marginal cost of production, monopoly is certain to exacerbate the already serious misallocative effects of underpricing health services. *See* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 55, 80–82. Allocative efficiency would be enhanced if U.S. health plans made their members face more cost and price differences, including those attributable to monopoly.

Even in the absence of monopoly, conventional health insurance enables consumers and providers to overspend on overly costly health care. This is, of course, the familiar effect of moral hazard—economists’ term for the tendency of patients and providers to spend insurers’ money more freely than they would spend the patient’s own. To be sure, some moral-hazard costs are justified as an unavoidable cost of protecting individuals against unpredictable, high-cost events. But American health insurers are significantly constrained in introducing contractual, administrative, and other measures to contain such costs.⁵⁴ U.S.-style health insurance is therefore more destructive of allocative efficiency than health insurance has to be. Although uncontrolled moral hazard is a problem throughout the health sector, combining inefficiently designed insurance with provider monopolies compounds the inefficiency—especially by making it easy for powerful tax-exempt firms to finance even more questionable health spending.⁵⁵

As noted above, the minimal requirements for tax exemption provide no assurance that the extraordinary surpluses gained by nonprofit-hospital monopolists are spent only to address individuals’ or society’s most pressing needs. Indeed, only if one takes the common but unthinking or self-serving view that health spending, like beauty, is its own excuse for being, is it possible to believe that nonprofit hospitals’ discretionary activities and projects necessarily represent socially appropriate uses for the resources consumed. Moreover, once tax-exempt hospitals capture surpluses from the payers of health insurance premiums, those resources are thereafter unavailable to meet even urgent non-health needs, individual or public as the case may be. For several decades, ever since private insurance, Medicare, and Medicaid substantially reduced hospitals’ charitable burdens and began to pour new resources into health care,

⁵⁴ See *supra* note 47. The impact of regulatory, legal, and contractual constraints on health insurers’ ability to contain moral hazard by stringently administering coverage can be appreciated by considering how far short today’s health plans fall of being in practice what they should be in theory: administrators of a common fund created by premium payers under contractual terms limiting the circumstances under which each of them may tap into it. To be sure, administrative costs inevitably limit what can and should be done. See *supra* note 13. But today, one sees virtually no explicit rationing of financing in the no-man’s-land of benefit/cost trade-offs and only occasional attempts to curb useless, “flat-of-the-curve” spending. See Pauly, *supra* note 47.

⁵⁵ Technically, the freedom of health-sector monopolists to set supra-monopoly prices is also a consequence of moral hazard and of U.S. insurers’ inability, as a practical matter, to counteract its cost-increasing effects. See *supra* note 47 and accompanying text.

nonprofit monopolies have been channeling funds into health care uses that, other than being charitably labeled “charitable” for tax purposes, have never been reliably legitimized as priorities by either market or political processes.⁵⁶ In the current deep recession, policies increasing spending on expensive but questionably or marginally valuable health services can only divert newly scarce (often borrowed) resources away from what many consumers or taxpayers might regard as far more essential uses.

The extraordinary profitability of health-sector monopolies causes resource misallocation of still another kind by greatly strengthening the usual inducement for firms to seek market dominance. Although some monopolies are earned by valuable innovation and other welfare-enhancing efforts, firms may also create and maintain market power in ways that waste scarce resources. Indeed, Richard Posner has theorized that monopoly’s most serious misallocative effect is not, after all, the output reduction recognized in theoretical models; instead, he observes how the prospect of lucrative monopoly induces firms to invest heavily in striving to obtain, defend, and extend market power and that there is no assurance that such striving for dominance will not fritter away most of (or even more than) the surpluses potentially capturable from consumers.⁵⁷ To be sure, firms’ general preference for reaping, rather than squandering, profits serves to ameliorate the potential for wasteful spending.⁵⁸ But managers of nonprofit firms, though they have no interest in profits as such, have incentives to build larger empires to enhance their self-esteem and status in the community and to justify increased perquisites for themselves.⁵⁹ Such empire building is most easily accomplished by

⁵⁶ In some states and situations, certain new discretionary spending by hospitals must be found worthy of a state-conferred “certificate of need” (CON). For a convincing demonstration that CON laws were originally designed to legitimize, not to contain, increased health care spending in the interest of powerful health insurers and the hospital industry, see Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203, 247–48 (1980). In any case, CON regulation mostly controls only the spending of money already earmarked for health care uses. On CON regulation limiting new entry into hospitals’ various markets, see *infra* note 91.

⁵⁷ RICHARD A. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* 13–18 (2d ed. 2001).

⁵⁸ William F. Baxter, *Posner’s Antitrust Law: An Economic Perspective*, 8 BELL J. ECON. 609 (1977) (book review).

⁵⁹ Thomas J. Philipson & Richard A. Posner, *Antitrust and the Not-for-Profit Sector* (Nat’l Bureau of Econ. Research, Working Paper No. 12132, 2006), available at <http://www.nber.org/papers/w12132.pdf>. Moreover, without freedom to distribute profits

obtaining market power and using it to generate surpluses with which to further entrench and extend the firm's dominance.

In light of the large share of gross domestic product already being spent on health care in the United States compared to every other nation in the world, the negative consequences of health-sector monopolies for efficiency in the economy's use of scarce resources provide an additional set of reasons to apply the antitrust laws with particular force against anticompetitive mergers and consolidations and against other practices by which providers and suppliers of health services and goods can achieve, entrench, and enhance market power. If antitrust enforcement is not up to the task of restoring competition in markets where it is lacking, regulatory measures may be called for.

IV

HOW ANTITRUST ENFORCEMENT FAILED IN HOSPITAL AND OTHER HEALTH CARE MARKETS

Getting competition policy right in every hospital market would have been difficult in any event, even if antitrust enforcers and courts had fully appreciated how health insurance facilitates monopolists' price gouging and if courts had possessed no illusions about the redistributive and allocative effects of nonprofit, tax-exempt hospitals. Technically, the Clayton Act, because it prohibits any merger having an anticompetitive effect "in any line of commerce . . . in any section of the country,"⁶⁰ would condemn any merger likely to cause net competitive harm in the market for even one of the many services that hospitals provide—unless some way could be found to avert the competitive harm, perhaps by spinning off a piece of the larger enterprise. Nevertheless, estimating likely competitive effects of a merger in each of the merging hospitals' many lines of business is a difficult and highly uncertain task.⁶¹ Moreover, many observers would naturally find it unreasonable to block a seemingly desirable

to owners or to pursue non-charitable purposes, managers of nonprofits have no alternative to reinvesting surpluses in health care.

⁶⁰ 15 U.S.C. § 18 (2006).

⁶¹ See U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 2, ch. 4, at 24.

Although the Agencies currently doubt the advisability and practicability of conducting separate product market analyses for many discrete markets—particularly when payors do not define the product they are purchasing in this fashion—the Agencies will continue to examine whether smaller product markets exist in addition to the traditional product market definition.

Id.

merger simply because the merged firm would be dominant in one or two submarkets.

Because of the difficulty of prospectively identifying and evaluating specific harms to competition from hospital mergers, antitrust enforcers and courts have been drawn to viewing the relevant “product market” not service-by-service but as a so-called “cluster market” for inpatient acute-care services.⁶² Although precedent and some logic support this approach,⁶³ its averaging of concentration levels in many markets necessarily obscures high levels of concentration in some of them, thus allowing some mergers of doubtful legality to go unchallenged.⁶⁴ Hospitals’ market power in such submarkets is also obscured by hospitals’ practice of negotiating a single formula for pricing all services together instead of separate prices for each service.⁶⁵ By not pricing their monopolized services individually, hospitals can exercise their market power under the radar, charging high prices for everything rather than astronomical prices for those services for which there is no close (or perfect) substitute.

Many hospital mergers also passed muster because efficiency considerations made them seem beneficial even when a very high level of concentration (measured by the government’s own guidelines) would result. In the 1980s, antitrust policy began to be friendlier to corporate mergers of all kinds. Specifically, merger analysis became explicitly receptive to efficiency claims and less

⁶² See, e.g., *In re Hosp. Corp. of Am.*, 106 F.T.C. 455 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986). Although agencies and courts are always free to look behind the aggregate for effects in markets for discrete services, they rarely do so, despite the principle enshrined in the Clayton Act that a procompetitive effect in one market cannot justify anticompetitive effects in another. See *Brown Shoe Co. v. United States*, 370 U.S. 294, 337 n.65 (1962); *Phila. Nat’l Bank v. United States*, 374 U.S. 321, 370 (1963) (rejecting the notion that “anticompetitive effects in one market could be justified by procompetitive consequences in another”). *But see* U.S. FED. TRADE COMM’N & U.S. DEP’T OF JUSTICE, *supra* note 2, ch. 4, at 24 (observing, as justification for using the cluster-market approach, that payers uniformly purchase bundled, not unbundled, hospital services); *infra* notes 86–91 and accompanying text.

⁶³ See generally Ian Ayres, *Rationalizing Antitrust Cluster Markets*, 95 YALE L.J. 109 (1985) (observing that the cluster-market approach may be justified where goods or services are in some way complementary in production, consumption, or distribution).

⁶⁴ See David Dranove, *Market Definition in Antitrust Analysis and Applications to Health Care*, in *MANAGED CARE AND CHANGING HEALTH CARE MARKETS* 121, 139 (Michael A. Morrisey ed., 1998) (finding “reasons to believe that traditional methods [of market definition] may create a bias in favor of [hospital] mergers that will turn out to harm consumers”).

⁶⁵ See *supra* note 46.

concerned simply with preventing concentration.⁶⁶ At the same time, new Medicare payment policies and other factors were creating excess hospital capacity by shortening stays and shifting services to ambulatory settings; mergers may therefore have seemed a good way both to facilitate downsizing and to realize apparent economies of scale.⁶⁷ In addition, because health insurers prior to that time had been largely passive payers rather than demanding purchasers, there was little empirical evidence to indicate that prices would be significantly higher if a market became concentrated. Hospital managements, on the other hand, could foresee that consolidating to achieve market dominance would pay dividends if and when purchasers became hard bargainers. The large number of hospital mergers essentially overwhelmed the ability of enforcers to scrutinize them with the requisite care.⁶⁸ Numerous consolidations of physician practices, often under the auspices of hospitals seeking assured, non-cost-conscious referrals, likewise eluded antitrust scrutiny.⁶⁹

Thus, many factors besides certain judges' sanguine attitude toward nonprofit monopolies contributed to what should now appear—once one recognizes the extraordinary pricing freedom that U.S.-style health insurance confers on monopolist providers and suppliers—to have been a colossally important failure of antitrust

⁶⁶ See U.S. DEP'T OF JUSTICE & U.S. FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 4 (2010) (listing potential efficiencies from a proposed merger as a criterion to inform enforcement decisions). But even if antitrust agencies and courts should respect efficiency claims in evaluating most mergers, they should treat such claims with special skepticism in the health sector. Not only can health insurance be expected to exacerbate the price-increasing, redistributive effects of provider monopolies "in any line of commerce," but the "problem of second best," see *supra* note 53, suggests that, with health insurance substantially lowering the prices patients pay, a strict antimerger policy is virtually certain to enhance allocative efficiency. Efficiency in the production of goods or services need not be deemed procompetitive for antitrust purposes if the resources being employed are likely to have better uses elsewhere in the economy.

⁶⁷ But see *supra* notes 43, 66.

⁶⁸ See Vogt, *supra* note 6 (reporting more than 900 mergers and acquisitions among U.S. hospitals, such that "[m]any cities came to be dominated by two or three large hospital systems"). Between 1987 and 1991, for example, the FTC challenged only five of some 227 hospital mergers. Ironically, the enforcement agencies have sometimes cited the small percentage of hospital mergers they have challenged as evidence of how reasonable their enforcement policy has been. See *Health Care Reform: Do Antitrust Laws Discourage Cost Cutters or Defeat Price Gougers?: Hearings Before the Subcomm. on Antitrust, Monopolies and Business Rights of the S. Comm. on the Judiciary*, 103d Cong., 1st Sess., at 27 (1993) (prepared statement of Janet D. Steiger, FTC Chairman).

⁶⁹ See, e.g., Meredith B. Rosenthal et al., *Managed Care and Market Power: Physician Organizations in Four Markets*, 20 HEALTH AFF. 187 (2001); Berenson et al., *supra* note 14.

enforcement. Today, in large part because of hospital mergers and other consolidations, there are few markets in which price competition keeps prices for specific hospital and other health care services and goods near their marginal cost.⁷⁰

V

A NEW ANTITRUST OR REGULATORY AGENDA?

Is there anything that government, through antitrust enforcement or otherwise, can now do about the problem of provider and supplier market power in health care markets? Although the enforcement agencies and courts should certainly scrutinize new hospital mergers and similar consolidations with greater skepticism, preventing new mergers cannot correct past failures to maintain competition in hospital and other markets. To be sure, enforcers may challenge the legality of previously consummated mergers, as the FTC did in the *Evanston Northwestern* case, but there are practical and judicial difficulties in fashioning a remedy that might restore the competition that the original merger destroyed. The FTC was unwilling, for example, to demand the dissolution of Evanston Northwestern Healthcare Corp. and instead merely ordered its jointly operated hospitals to negotiate separate contracts with health plans—a remedy, incidentally, that gave the negotiating team of neither hospital any reason to attract business from the other.⁷¹ Although the FTC might seek more substantial relief in other such cases, the general rule seems to be that old, unlawful mergers are amenable to later breakup only in the unusual case where the component parts have not been significantly integrated.⁷² In any case, given their past skepticism about antitrust enforcement in health care markets, courts would be hard to enlist in an antitrust campaign to roll back earlier consolidations. A policy agenda capable of redressing the provider monopoly problem in health care will need to employ other legal and regulatory instruments.

⁷⁰ See *supra* note 6.

⁷¹ Despite losing thoroughly on the merits, the respondent declared itself “thrilled” with the FTC’s remedy. *FTC Ruling Keeps Evanston Northwestern Healthcare Intact*, N. SHORE UNIV. HEALTH SYS. (Aug. 6, 2007), <http://www.northshore.org/about-us/press/press-releases/press-release-archives/ftc-ruling-keeps-evanston-northwestern-healthcare-intact.aspx>.

⁷² *E.g.*, *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586 (1957); see also 5 PHILLIP AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW* ¶ 1205b (2d ed. 2003).

A. *The Special Problem of Accountable Care Organizations*

A first order of business in fighting provider market power is to prevent accountable care organizations (ACOs) from aggregating such power. The PPACA encourages providers to integrate themselves in ACOs for the purpose of implementing “best practices” and thereby providing coordinated care of good quality at low cost.⁷³ As an inducement for providers to form and practice within these presumptively more efficient entities, the PPACA instructs the Medicare program to share with an ACO any cost savings it can demonstrate.⁷⁴ Observers are now expressing concern, however, that ACOs—whatever their value to Medicare may be—will attain and exercise substantial market power vis-à-vis private health plans.⁷⁵ *The New York Times* has reported “a growing frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings, and cash in on the [ACO program’s] incentives.”⁷⁶ In fact, providers’ main purpose in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen their market power over purchasers in the private sector.

⁷³ See generally Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293 (2010). Health policy experts have long recognized the benefits of vertically integrating providers working at different stages of the delivery system—primary care physicians, nurse practitioners, various specialists, outpatient clinics, hospitals, and pharmacies. Coupled with user-friendly information technology and compensation systems that reward efficient practice, vertical integration can enable professional and institutional providers to coordinate and rationalize their efforts with the goal of delivering high-quality, low-cost, patient-centered care. See, e.g., Alain C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency*, HEALTH AFF. WEB EXCLUSIVE, W5-420, Sept. 7, 2005, <http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420.full.pdf+html>. Conversely, there are recognized harms from maintaining a fragmented health care system. See EINER ELHAUGE, *THE FRAGMENTATION OF U.S. HEALTH CARE* (2010).

⁷⁴ PPACA, Pub. L. No. 111-148, §§ 3022, 10307, 124 Stat. 119, 395–99, 940–41 (2010). Just how savings and quality are to be measured and rewarded—both seemingly daunting tasks—remains to be determined in regulations due by January 2012.

⁷⁵ AM.’S HEALTH INS. PLANS, ACCOUNTABLE CARE ORGANIZATIONS AND MARKET POWER ISSUES (2010); Berenson et al., *supra* note 14, at 1 (noting ACOs’ “potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power”); Jeff Goldsmith, *Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms*, 29 HEALTH AFF. 1299, 1304 (2010) (“Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen.”).

⁷⁶ Pear, *supra* note 7.

Although the PPACA appears designed to achieve the benefits of vertical integration for Medicare and its beneficiaries, it inevitably invites horizontal integration that creates new market power in private markets.⁷⁷ The formation of ACOs should therefore be subject to close antitrust scrutiny.⁷⁸ As noted, the new law provides a strong predicate for ACOs' efficiency claims, which, under conventional antitrust reasoning, can trump concern about concentration on the seller side of the market. Nevertheless, conventional reasoning should not guide antitrust evaluations of mergers and consolidations in health care markets. Instead, our observation that health insurance greatly exacerbates the anticonsumer, redistributive, and misallocative effects of monopoly provides a strong warrant for an especially stringent anti-concentration, antimerger policy in the health care sector.⁷⁹ Notwithstanding the special efficiency claims that can be made on behalf of ACOs, therefore, we believe their presumed efficiencies should count for little in appraising an ACO's likely market impact.

To be sure, claims of private-sector efficiencies cannot be wholly ignored in antitrust analyses of ACOs. They should be viewed with skepticism, however. The efficiencies expected of ACOs flow mostly, after all, from vertical integration of providers, not from combining competitors horizontally. Antitrust authorities might therefore reasonably oppose any ACO formation that increases horizontal concentration to a troublesome level "in any line of commerce." Such concentration matters because, especially with

⁷⁷ Indeed, one provision in the PPACA seems to necessitate powerful combinations in smaller markets by requiring an ACO to include enough providers to care for at least 5000 Medicare beneficiaries. 42 U.S.C. § 1395jjj(b)(2)(D). Enacted with the Medicare program principally in mind, this provision should not be read as a congressional relaxation of antitrust constraints on ACO formation. Indeed, antitrust enforcement against ACOs in smaller markets might encourage Congress to modify its anticompetitive requirement and perhaps even to adopt new regulatory protections for competition in private markets.

⁷⁸ In the absence of an explicit statutory exemption or directive, any benefits to Medicare should carry no weight in an antitrust analysis of an ACO's effect on competition. Accordingly, physicians and hospitals organizing ACOs have asked federal officials for exemptions. Pear, *supra* note 7.

⁷⁹ To see how our observation has yet to inform discussions of ACO market power, consider the following understatement appearing (twice) in a recent white paper on ACOs issued by the health insurance industry's principal trade association: "As with other industries, health care is not immune from the laws of market power and its impact on competition." AM.'S HEALTH INS. PLANS, *supra* note 75, at 1, 3. A deeper analysis would emphasize that health care is *not* like other industries because powerful providers of insured services have unique opportunities to exploit the consuming public.

health insurance in the picture, consumers cannot expect to realize savings from ACOs' putative efficiencies unless providers of nearly all services face active competition in selling to cost-conscious private payers.⁸⁰ In any event, ACO efficiencies from vertical integration should be regarded as speculative in particular cases—and not merely because reformers' hopes and dreams do not always translate automatically into real-world improvements but may instead have unintended consequences.⁸¹ Although integrated delivery systems have developed spontaneously in the past and serve as models for the reformers' aspirations, efforts to replicate those early successes have often failed, in part because many physicians are reluctant to forgo the lucrative possibilities of unconstrained fee-for-service practice.⁸² Moreover, many ACOs are reportedly being sponsored by hospitals, which any efficient delivery system would use sparingly and which may therefore be moving to preempt control of ACOs so any cost savings will come at the expense of others and not themselves.

In order for antitrust law and regulation to effectively contest the formation of powerful ACOs, a proposed ACO ought to go through a rigorous pre-approval process like that routinely employed in

⁸⁰ On how bundling services for negotiating purposes allows monopoly to infect all prices, see *supra* note 46 and *infra* notes 86–91 and accompanying text. It is unlikely that there would be any efficiency antitrust defense for an otherwise objectionable merger if the savings from expected efficiencies achieved are unlikely to benefit consumers in the form of lower prices. The government's position is that "efficiencies almost never justify a merger to monopoly or near-monopoly." U.S. DEP'T OF JUSTICE & U.S. FED. TRADE COMM'N, *supra* note 66, § 10, *accord* Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1223 (11th Cir. 1990) ("[A] defendant who seeks to overcome a presumption that a proposed acquisition would substantially lessen competition must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers."). With health insurance increasing the magnitude of monopolists' price increases, there is little prospect of consumer benefit unless price competition remains robust in virtually all submarkets. For this reason and also because the excessive cost of health care in the United States already amounts to several whole percentage points of gross domestic product, see, e.g., Havighurst & Richman, *supra* note 9, at 11 n.8, and is mostly attributable to the monopoly prices charged for provider services, see *infra* note 99, antitrust agencies and courts have ample reasons to attack concentration head-on. Although providers will argue that consumers will benefit as patients from the quality improvements ACOs are expected to achieve, new dollar costs to consumers are a far more certain consequence of overly powerful ACOs.

⁸¹ Shortell et al., *supra* note 73 (suggesting how the heavy hand of bureaucracy may be needed to improve the chances that ACOs will succeed in improving Medicare as the reformers hope).

⁸² See Havighurst, *supra* note 53, at 64–67.

screening large corporate mergers under the Hart-Scott-Rodino Act.⁸³ Because of the large number of proposed consolidations and joint ventures and because screening them for effects in discrete submarkets—as opposed to arbitrarily defined cluster markets—is a labor-intensive job, the burden of showing an absence of significant horizontal effects in local submarkets might reasonably be assigned to an ACO's proponents. As is common in screening other mergers, antitrust officials should be open to possibilities for curing concentration problems by spinning off certain services or by excluding some proposed participants from the joint venture. Nonexclusive contractual arrangements with certain ACO providers, allowing them to participate freely in competing networks, might lessen antitrust concerns.

Additional protection against ACOs' exercise of market power vis-à-vis private purchasers could also be provided in Medicare's forthcoming regulations governing ACOs. For example, Medicare might bar an ACO from marketing to private payers until it has demonstrated its ability to achieve quality improvements and substantial cost savings for Medicare itself.⁸⁴ In addition, the Medicare program might condition its sharing of savings with an ACO on the latter's demonstration that its prices to private payers have not increased due to an increase in its market power in any market. One might wonder, of course, whether a governmental single payer like Medicare would ever have the mission, the impulse, or the requisite creativity to be helpful in making private markets for health services effectively competitive. The more likely scenario, unfortunately, is that Medicare will be happy to see costs shifted to the private sector—and may even reward ACOs' cost shifting as cost savings.⁸⁵

⁸³ 15 U.S.C. § 18a (2006). Hospital mergers and mergers of medical practices have generally been too small to meet Hart-Scott-Rodino dollar and other thresholds for prior notification to the antitrust agencies.

⁸⁴ An antitrust court also might suspend operation of an ACO in the private sector until it could show that it saved money for Medicare.

⁸⁵ To be sure, the notion of "cost shifting"—the idea that providers can readily raise their prices to private payers to recoup whatever they may lose because Medicare decides to pay them less—has been discredited because even a monopolist provider would most likely be charging private payers a profit-maximizing price already. See Havighurst & Richman, *supra* note 9, at 22 n.40. But an ACO program that allows Medicare to realize cost savings by fostering increases in providers' market power vis-à-vis the private sector (and thus the prices it could profitably charge) would represent a kind of cost-shift on Medicare's part. Just as the FTC in the *Evanston Northwestern* merger case used post-merger prices to show that the merger created new market power and should have been

Not only does the public interest require that law and regulation contest the formation of powerful new ACOs, but measures must also be taken to weaken the strategic positions of existing systems with ACO-like characteristics. The following subsections suggest some additional ways (besides enlisting Medicare in policing ACO market power) in which antitrust principles and regulatory powers might be employed to strengthen price competition in markets already featuring dominant providers.

B. Requiring Unbundling of Monopolized Services

As a strategy to restore competition in health care markets, antitrust enforcers might focus their efforts on requiring hospitals and other provider entities to unbundle, at a purchaser's request, their competitive and monopolized services for purposes of negotiating prices. Although there has been no enforcement effort aimed at hospitals' tying their services together in bargaining with private payers,⁸⁶ such tying should be vulnerable to antitrust attack even if bundling generally makes for efficient negotiating.⁸⁷ The general antitrust rule on tying is that a firm with market power may not use it to force customers to purchase possibly unwanted goods or services.⁸⁸ If this principle could be invoked to frustrate hospitals' practice of

prohibited when it occurred, Medicare might insist that a newly formed ACO be "accountable" for its prices to private payers before Medicare's cost savings are treated as net social ones.

⁸⁶ In a private suit, a dominant hospital chain was sued by its lone rival for, among other things, bundling primary and secondary services with tertiary care in selling to the area's insurers. *See Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 890–91 (9th Cir. 2008). The district court permitted certain claims to proceed to trial, including a claim of illegal bundled discounts, but dismissed the tying claim.

⁸⁷ Einer Elhauge has recently advocated stricter enforcement of the rule against tying. *See Einer Elhauge, Tying, Bundled Discounts, and the Death of the Single Monopoly Profit Theory*, 123 HARV. L. REV. 397 (2009). His reasoning confirms our sense that permitting a hospital monopolist to tie unrelated services expands the monopoly's reach, profitability, and longevity and harms consumer welfare. We would further argue that, even though there are some efficiencies from bundling, antitrust law should permit a purchaser to demand separate prices where the added cost of bargaining service by service is offset by the prospect of lower prices. *See ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 96* (2007), available at <http://purl.access.gpo.gov/GPO/LPS81352> ("In the case of *de facto* tying, while consumers are free to buy components separately, the components are priced to make it more attractive to buy the bundled components together. Under this theory, the prices of the components are actually increased, including the stand-alone price of the monopolized good. Thus, instead of receiving a discount, consumers are actually paying more for the bundled products.").

⁸⁸ *See Jefferson Parish Hosp. Dist. No. 2. v. Hyde*, 466 U.S. 2 (1984).

negotiating a comprehensive pricing formula for large bundles of their services, purchasers could then bargain down the prices of those services having good substitutes.⁸⁹ If a hospital still wished to fully exploit its various monopolies, it would have to do so in discrete negotiations, making its highest prices visible. Health plans could then hope to realize significant savings by challenging such monopolies, which they could do by adopting purchasing policies and enrollee incentives designed to expand the geographic market or encourage new entry. For example, a health plan might provide substantially more favorable coverage (lower copayments, for example) for patients willing to seek certain treatments farther from home⁹⁰ or at a startup facility. Even where certificate-of-need regulation bars free entry,⁹¹ an insurer's favorable long-term contract

⁸⁹ The ability to leverage market power in one sub-market into price increases in a competitive market helps explain wide price variation for like services in common geographic markets. See GINSBURG, *supra* note 49.

⁹⁰ Some self-insured employers have already pursued the promise of searching outside local markets to provide health care for their employees. North Carolina-based Lowe's Company, Inc., for example, now encourages its employees to travel to the Cleveland Clinic for heart procedures, citing the Clinic's superior outcomes and lower costs compared to local providers. See Harlan Spector, *Lowe's Will Bring Its Workers to Cleveland Clinic for Heart Surgery*, PLAIN DEALER (Cleveland), Feb. 17, 2010, http://www.cleveland.com/healthfit/index.ssf/2010/02/post_27.html ("The arrangement was attractive enough that Lowe's will pay travel and lodging expenses for patients and a companion, and waive a \$500 deductible and other out-of-pocket costs."). Insurers, not just self-insured employers, are also searching for out-of-network providers to provide care for their subscribers. See *Mayo Clinic and UnitedHealthcare Announce New Network Relationship*, MAYO CLINIC (Oct. 7, 2010), <http://www.mayoclinic.org/news2010-rst/5993.html> (announcing that United Healthcare's insureds across the United States can seek care from Mayo Clinic physicians and hospitals as in-network providers); Jennifer Lubell, *New Tourist Attractions*, MODERN HEALTHCARE, June 15, 2009, at 28 (reporting that many specialty hospitals in the United States are seeking to attract patients from U.S. insurance companies and other medical intermediaries). U.S. insurers are also sending their subscribers abroad. See M.P. McQueen, *Paying Workers to Go Abroad for Health Care*, WALL ST. J., Sept. 30, 2008, <http://online.wsj.com/article/SB122273570173688551.html> ("Insured Americans are starting to see some unusual options in their health-provider networks: doctors and hospitals in Singapore, Costa Rica and other foreign destinations."). Providers outside the United States, in the Cayman Islands and India, for example, are similarly marketing themselves to self-insured employers and insurers seeking high-quality services at competitive prices for their subscribers. See Geeta Anand, *The Henry Ford of Heart Surgery*, WALL ST. J., Nov. 25, 2009, <http://online.wsj.com/article/SB125875892887958111.html> (detailing plans to build a 2000-bed general hospital in the Cayman Islands where "[p]rocedures, both elective and necessary, will be priced at least [fifty percent] lower than what they cost in the U.S."); Barak D. Richman et al., *Lessons from India in Organizational Innovation: A Tale of Two Heart Hospitals*, 27 HEALTH AFF. 1260 (2008).

⁹¹ A continually debated issue is the appropriateness of employing CON laws or other measures to prevent specialty hospitals and ambulatory surgical facilities from competing

with a prospective entrant, entered into to avoid paying a monopolist's high price, might serve (assuming an enlightened regulator) to establish "need" for a competitive alternative to a dominant provider. In fact, the mere threat of new entry would often be sufficient to modify the monopolist's demands.

Unfortunately, inevitable litigation delays and legal uncertainty provide good reasons not to rely exclusively on antitrust law to promptly and effectively preclude provider monopolists from exercising their market power over some services by bundling them with others in dealing with purchasers. However, at some level, properly empowered regulators could enable individual payers to demand unbundling in particular cases in order to facilitate their efforts to get better prices, both in submarkets where monopoly is not a problem and also where it is. Of course, one hopes that antitrust courts and a credible threat of treble damages would discourage a provider monopolist from retaliating against any purchaser that aggressively challenges its dominant position and the anticompetitive practices used to maintain it.

C. Challenging Anticompetitive Terms in Insurer-Provider Contracts

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

with full-service hospitals. See, e.g., Clark C. Havighurst, *From the Field: Monopoly Is Not the Answer*, HEALTH AFF. WEB EXCLUSIVE, W5-373, Aug. 9, 2005, available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.373>; Sujit Choudhry et al., *MarketWatch: Specialty Versus Community Hospitals: What Role for the Law?*, HEALTH AFF. WEB EXCLUSIVE, Aug. 9, 2005, available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.361>.

substantial price increase only after Partners agreed to “protect Blue Cross from [its] biggest fear: that Partners would allow other insurers to pay less.”⁹²

Antitrust law may well offer some remedy against a provider monopolist agreeing to an MFN clause to induce a powerful insurer to pay its high prices. But the availability of that remedy (which would probably be only a prospective cease-and-desist order rather than an award of treble damages for identifiable harms) might not be sufficient to deter a powerful provider from granting MFN status to a dominant insurer. Regulatory authorities, however, could presumably prohibit dominant providers from conferring such status. Such agreements by providers, by restricting their freedom to cut price deals with a preferred customer’s competitors, reduce pressure on, and opportunities for, all insurers to “get the best deal possible.”⁹³ Protected against their competitors’ getting better deals, insurers are likely to give in too quickly to monopolists’ price demands.

A more potent antitrust attack on anticompetitive MFN clauses would aim at the dominant insurer demanding them, rather than at the cooperating provider. The Department of Justice (DOJ) has recently sued Blue Cross Blue Shield of Michigan, a dominant insurer, to enjoin it from using MFN clauses in its contracts with Michigan hospitals; the DOJ alleged that such restrictions on provider price competition have reduced competition in the insurance market by preventing other insurers from negotiating favorable hospital contracts.⁹⁴ Because the MFN clauses in the Michigan case are alleged—and seem likely—to have raised prices paid by Blue Cross’s competitors and by self-insured employers, they provide promising targets not just for public enforcement but also for private treble-damage actions by injured purchasers, in which damages would be measured by any higher costs that the restrictions forced them to incur. Indeed, in the wake of the government’s initiative in Michigan, the threat of private lawsuits should quickly end the use of MFN

⁹² *A Handshake That Made Healthcare History*, *supra* note 31. The Massachusetts Attorney General has noted that such payment-parity agreements have become “pervasive” in provider-insurer contracts in the commonwealth and has expressed concern that “such agreements may lock in payment levels and prevent innovation and competition based on pricing.” HEALTH CARE COST TRENDS, *supra* note 28, at 40–41.

⁹³ *See infra* note 95.

⁹⁴ *See* Complaint at 1–2, *United States v. Blue Cross Blue Shield of Mich.* (E.D. Mich. 2010) (No. 2:10-CV-14155); *see also* David S. Hilzenrath, *U.S. Files Antitrust Suit Against Michigan Blue Cross Blue Shield*, WASH. POST, Oct. 18, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/10/18/AR2010101805257.html>.

agreements by large insurers.⁹⁵ In Massachusetts, for example, the Blue Cross plan should now think long and hard before renewing (or enforcing) the MFN clause in its contract with Partners HealthCare.

Other contract provisions that threaten price competition are also in use in provider-insurer contracts in Massachusetts, according to the Commonwealth's Attorney General.⁹⁶ In particular, so-called "anti-steering" provisions prohibit an insurer from creating insurance products in which patients are induced to patronize lower-priced providers. Under such a contractual constraint, a health plan could not offer more generous coverage—such as reduced cost-sharing—for care obtained from a new market entrant or from a more distant, perhaps even an out-of-state or out-of-country, provider.⁹⁷ Other contractual terms in use in Massachusetts (and presumably in other jurisdictions as well) guarantee a dominant provider that it will not be excluded from any provider network that the health plan might offer its subscribers.

⁹⁵ Dominant insurers may have felt free to impose MFN clauses on providers because the courts have not made clear when, as a matter of antitrust law, they may not. *Cf.* *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1415 (7th Cir. 1995) (qualifying the court's earlier blanket approval of MFNs by adding the following sentence to its opinion: "Perhaps, as the Department of Justice believes, [MFN] clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case."). In four significant cases brought by private plaintiffs, federal appellate courts have upheld practices of Blue Cross or Blue Shield plans that, in the court's view, seemed intended only to assure them favorable prices. *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989); *Ball Mem. Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986); *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984); *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80 (3d Cir. 1973). In the two cases brought by a competitor of the Blue defendant, however, the court badly misread the evidence. Thus, in *Travelers* (the case from which the courts in *Kartell* and *Ocean State* quoted language approving efforts to "get the best deal possible"), the payer was acting in tacit collusion with a hospital cartel, not driving hard bargains with individual hospitals. See CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 1345–52 (2d ed. 1998); Clark C. Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in *HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE* 221, 251–52 (H.E. French III ed., 1988). Likewise, in *Ocean State*, the Blue Shield plan's MFN clause should have been read not as an effort to pay physicians less but as an offer to pay them more if they ceased discounting their services to a competing HMO that was threatening the defendant's position as virtually the sole marketing agent for physicians in Rhode Island. See HAVIGHURST ET AL., *supra*, at 1360–72. It is probable that the government's case in Michigan will confirm the anticompetitive character of MFN clauses used pervasively by a dominant insurer, thus laying groundwork for future private actions and effectively deterring the objectionable practice.

⁹⁶ See *HEALTH CARE COST TRENDS*, *supra* note 28, at 40–44.

⁹⁷ See *supra* note 90.

The contractual terms noted here all have the potential to foreclose opportunities for consumers to benefit, both directly as patients and indirectly as premium payers, from innovative insurance products that competing health plans might otherwise introduce. Not only might antitrust rules be interpreted to prohibit the use of such anticompetitive contract terms to protect provider monopolies and curb insurer innovation, but insurance regulators might bar such provisions wherever they threaten to preclude effective price competition. In at least some cases, the latter regulatory course may be preferable to reliance on cumbersome antitrust remedies, especially if the deterrent effect of private, treble-damage suits seems insufficient to increase insurers' incentive and opportunities to innovate.

VI

CONCLUSION

As stated at the outset, our purpose here has been to call attention to the unusually serious consequences, for both consumers and the general welfare, of monopolies in health care markets. Our main point, however, is not merely that monopoly is ubiquitous in such markets—although we have pointed to some evidence that it is, particularly when so-called cluster markets are disaggregated into discrete submarkets for particular services. Nor have we intended to attribute the prevalence of health care provider market power principally to past failures of antitrust enforcement—although we have stressed the difficulty the government has had in preventing anticompetitive mergers of nonprofit hospitals and the consolidation of physician practices.⁹⁸ Our principal point is that health insurance, especially as it is designed and administered in the United States, hugely expands monopolists' pricing freedom, making monopoly's wealth-redistributing and misallocative effects substantially more serious than monopoly's effects usually are. Although this point has been almost completely absent from the antitrust and economics literature,⁹⁹ its importance would seem to dwarf all other

⁹⁸ We are cognizant, for example, that market power exists in many health care markets and submarkets because of economies of scale (creating natural-monopoly conditions), entry barriers, exclusionary licensure or CON requirements, significant product differentiation, valid patents, trade secrets, and first-mover advantages. For an assortment of reasons, some provider monopolies are an inescapable fact of life in U.S. health care.

considerations in accounting for the extraordinarily high cost of U.S. health care.¹⁰⁰

To mitigate the harms from provider market power, we advise vigorous, rather than tentative or circumspect, enforcement of the antitrust laws. Retrospective scrutiny of earlier horizontal mergers of hospitals or other providers could help correct decades of ineffectual enforcement. An antitrust or regulatory initiative to curb hospitals' tying practices and to prohibit anticompetitive contracts between payers and providers—perhaps as remedies for earlier mergers found unlawful after the fact—might also significantly reduce the extraordinary pricing freedom that hospital and other monopolists enjoy by virtue of U.S.-style health insurance.¹⁰¹ By enabling competing health plans to bypass, or foster new competitors for, local monopolists, such antitrust or regulatory actions could promote price competition where it is currently lacking.

Unfortunately, health insurers are far less eager to contest provider market power and to act as aggressive purchasing agents of consumers than they would be if consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it.¹⁰² Currently, when it comes to their

⁹⁹ Although scholars have previously observed that prices for health services are much higher in the United States compared to other nations in the Organization for Economic Co-operation and Development (without observable differences in quality), see, e.g., Gerard Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003), and although many have observed that provider market power is a factor in inflating those prices, see *supra* note 6, few have observed the synergistic effects of monopoly and health insurance. Indeed, although Anderson et al. note “varying degrees of monopoly power on the sell side of the market,” their only other suggested explanation for high prices is that “the buy side of the U.S. health system is relatively weak by international standards.” Anderson et al., *supra*, at 102. The authors seem not to recognize that health insurance *itself* raises monopolists' prices or that the private “buy side” is especially (for reasons given *supra* notes 45–51 and accompanying text), although not inevitably, helpless in fighting cost battles in the U.S. system.

¹⁰⁰ Excess health care spending in the United States was recently estimated to be \$650 billion per year, equal to nearly five percent of gross domestic product. See ERIC JENSEN & LENNY MENDONCA, NAT'L INST. FOR HEALTH CARE MGMT. FOUND., *WHY AMERICA SPENDS MORE ON HEALTH CARE* (2009), available at http://nihcm.org/pdf/EV_JensenMendonca_FINAL.pdf.

¹⁰¹ *But see* U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 2, ch. 4, at 24 (observing that insurers generally prefer to purchase bundled, not unbundled, hospital services).

¹⁰² The inefficiency of U.S. private health insurance arises in large measure because the tax system treats employer-provided coverage as a tax-free benefit, with the result that workers tend to lose sight of the full cost of their coverage and are therefore reluctant, both

health care, insured consumers are unduly reluctant to accept anything less than the very best—close substitutes, for example. U.S. health plans are therefore inadequately incentivized to reduce costs and overly hesitant to adopt innovative strategies with associated legal or political risks. Any hopefulness we may have about the future of U.S. health care is tempered by doubts about the ability and willingness of U.S. health insurers to take the aggressive actions needed to procure appropriate, affordable care.

The PPACA, by providing conventionally generous health insurance to many million more Americans, has the potential to enshrine the significant shortcomings of such insurance. Not only does the new law seem to have no effective answer to the problem of provider/supplier monopoly,¹⁰³ but its broad extension of coverage is likely to further amplify the uniquely harmful effects of provider and supplier market power. Whatever the PPACA may achieve, its legacy and cost to the nation will depend largely on whether market actors, regulators, and antitrust enforcers can effectively address the provider monopoly problem. In the near future, the cost problem may become so serious that the temptation to adopt draconian measures, such as direct price controls, will be irresistible.¹⁰⁴ Competition-oriented policies are still available, however, and could yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources newly limited by a major recession.

as consumers and as voters, to tolerate any measure that might facilitate economizing. Health insurers are therefore in a poor position, particularly in the politicized regulatory environment they confront, to act as cost-conscious purchasing agents for consumers in contesting provider market power. *See* Havighurst & Richman, *supra* note 9, at 36–39; *supra* notes 45–51 and accompanying text.

¹⁰³ Indeed, by encouraging hospitals and physicians to combine forces to create ACOs, the PPACA may actually prompt and enable providers to gain more market power. *See supra* text accompanying notes 73–85.

¹⁰⁴ Some generally market-oriented scholars have already concluded that “[b]ecause antitrust policy has proved ineffective in curbing . . . providers’ market power to win higher payments, policy makers need to consider approaches including price caps and all-payer rate setting.” Berenson et al., *supra* note 14.

