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I. INTRODUCTION

The past few years have been marked by increased consolidation among health care providers. Hospitals are merging with each other, physician groups are combining to create much larger, often single specialty practices, and hospitals are acquiring or employing an ever-growing number of physicians. Some observers have suggested that the Patient Protection and Affordable Care Accountable Care Act ("PPACA")[2] has encouraged this consolidation, and that the Act will prompt even greater consolidation—with adverse competitive effects—as providers form accountable care organizations ("ACOs"), which under the Act have the potential to share savings with the Medicare program but which also will likely negotiate with commercial health plans on behalf of independent providers.[3] Is this, then, an example of contradictory government policies that ultimately will make it even more difficult to rely on competition to reduce health care costs and improve quality?

The short answer is "not necessarily," but changes in the health care sector will require antitrust enforcers and health care regulators to apply more sophisticated approaches to ensure that our reliance on competitive health care markets is well-placed. Some of the health care sector changes are a result of or will be hastened by PPACA, but others would have occurred in any case, even without the passage of federal health care reform.

II. THE CHALLENGES OF RELYING ON COMPETITIVE HEALTH CARE MARKETS

The causes of the market failures that are present in health care markets are well-recognized. An employer-based health insurance system insulates the patient who "consumes" health care services from much of the actual costs of health care, which are paid by employers

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[2] Patient Protection and Affordable Care Act, Pub. L 111-48 124 Stat. 119 (2010).

[3] *See e.g.* Statement of Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute, before the House Committee on the Judiciary Subcommittee on Intellectual Property, Competition and the Internet at Hearing on "Health Care Consolidation and Competition after PPACA" (May 18, 2012), http://www.aei.org/files/2012/05/18/-scott-gottlieb-testimony_094622558298.pdf; Havighurst & Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 872-875 (2011). *But see* Statement of Thomas L. Greaney, Professor of Law, St. Louis University School of Law before the House Committee on the Judiciary Subcommittee on Intellectual Property, Competition and the Internet at Hearing on "Health Care Consolidation and Competition after PPACA" (May 18, 2012), http://judiciary.house.gov/hearings/Hearings%202012/Greaney%2005182012.pdf (arguing that PPACA encourages pro-competitive consolidation and is aimed at addressing some of the market failures that have plagued health care competition).

who contract for health care services that are often ordered by physicians who have little financial incentive to assure that care is furnished in the most cost-efficient manner. Because of information asymmetries and the difficulties in measuring health care quality, those who order and receive health care services are often in a poor position to determine the value of the services. Entry barriers, many imposed by the government such as certificate-of-need and licensure, are high. Consumer preference for broad provider networks makes it difficult for health plans to selectively contract. And, in at least some cases, courts have been receptive to the argument that either because of the professional nature of the services, or the non-profit status of a provider, some special consideration may be warranted when applying antitrust laws in the health care sector.[4]

In addition to all of the above, a crucial factor that further complicates application of antitrust to health care is the role of government as the dominant purchaser. In 2009, Medicare and Medicaid accounted for approximately 47 percent of the average hospital's revenue and 29 percent of the average physician's revenue, although this amount varies by geographic location and mix of services.[5] Moreover, these percentages will rise in the coming years as more baby boomers qualify for Medicare, and Medicaid rolls grow under PPACA, at least in those states that do not opt out of expanded Medicaid coverage.

There are two key implications that flow from the government's—and especially Medicare's—role as the largest purchaser by far of health care services.[6] First, the incentives embedded in the Medicare payment system have a huge impact on how providers structure and conduct themselves. This is not only because Medicare directly pays for so much of what they do, but also because other payers in both the public and private sphere generally model their payment approaches around the Medicare program. Medicare reimbursement has been largely based on a fee-for-service model that rewards greater utilization, does not incentivize coordination among health care providers, and does not differentiate payment amounts based on quality.[7] One consequence of this system is that providers generally do not compete on price for Medicare patients; there may be non-price competition on the part of providers to attract patients directly, or to attract physicians who will refer or admit patients, but such competition is hampered by the lack of incentives and useful data that can be used to identify those providers that provide higher value, i.e. better quality or lower cost.

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[4] *See e.g. Federal Trade Commission v. Butterworth Health Corp,* 946 F. Supp. 1285, 1302 (W.D. Mich. 1996) (asserting that "nonprofit hospitals operate differently in highly-concentrated markets than do profit-maximizing firms").

[5] *See* Medical Payment Advisory Commission, June 2011 Data Book, Health Care Spending and the Medicare Program, at 6, *available at* http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf [hereinafter "MedPAC 2011 Data Book"].

[6] For a more extended discussion of the ways that government, as both purchaser and regulator, affects hospital markets, *see* Hammer & Sage, *Critical Issues in Hospital Antitrust Law*, 22(6) HEALTH AFFAIRS 88 (Nov/Dec. 2003).

[7] This discussion applies to the traditional fee-for-service Medicare program. Medicare Advantage, which covers about 27 percent of Medicare beneficiaries, relies on health plans to cover Medicare beneficiaries using managed care approaches that are similar to those used to cover individuals that are privately insured. *See* M. Gold, *et.al.*, *Medicare Advantage 2012 Data Spotlight: Enrollment Market Update*, Kaiser Family Foundation Medicare Coverage, 2012, *available at* http://www.kff.org/medicare/upload/8323.pdf.

Second, the financial bottom line for most health care providers is heavily dependent on what and how Medicare pays. If Medicare payment per service is reduced substantially, providers will more aggressively seek out ways to reduce costs and increase revenues, the latter either by increasing utilization or seeking more revenues from non-Medicare patients.[8]

III. THE PROVIDER SECTOR REACTION TO HEALTH CARE REFORM

PPACA is widely viewed as insurance reform legislation that does little to address underlying health care costs. The law, however, does contain several provisions aimed at planting the seeds for more fundamental changes in Medicare payment policy.

The initiative that has gotten the most attention is the Medicare Shared Savings Program ("MSSP") whereby providers organized into ACOs can share the savings (and eventually be at risk for a share of excess costs) associated with providing care to a defined set of Medicare beneficiaries, with the level of payment also being affected by aggregate scores on a variety of quality measures. Other provisions of the Act establish a Center for Medicare and Medicaid Innovation with a $10 billion dollar budget for fiscal years 2011- 2019,[9] whose goal in part is to experiment with various innovative ways to structure Medicare payment.

These are largely targeted at achieving the same goals of ACOs—*i.e.* to develop ways in which providers will have incentives to work more closely together across different specialties and settings to improve the overall value of the health care services they provide so that patients receive better quality care, including improved preventive and chronic care services, that result in an overall reduction in health care costs. Such initiatives include payment based on "episodes of care" that involves bundling into a single payment all of the costs associated with a procedure or illness, and the use of "patient centered medical homes" that involve greater coordination by, and reimbursement of, primary care physicians of a wide range of services, many of which have traditionally been under-reimbursed or not paid for at all.

Notwithstanding (at least until recently) the uncertainty of whether PPACA would be overturned, and the somewhat limited nature of these initiatives, the provider community generally has embraced the notion that—sooner or later—both Medicare and private health plans are going to adopt payment reforms that will reward efficient, higher quality providers, and punish those who are not. As a result, there has been a tremendous amount of interest in developing ACOs, or ACO-like approaches, and gathering data and exploring ways to integrate across providers. Most of this should be pro-competitive or competitively neutral. For example, the most significant kinds of integration to build a successful ACO involve providers either contracting or merging with providers of complementary services, *i.e.* not involving horizontal agreements or mergers among competitors.

The movement towards ACOs and similar payment reforms might prompt physicians in very small practices to merge to create the scale to invest in infrastructure, such as an IT system, that would be useful in responding to "value-based purchasing" initiatives, but given the large number of small physician practices, there is room for much of this sort of consolidation without

[8] *See* MedPAC 2011 Data Book at 84.

[9] *See* "Fiscal Year 2013: Budget In Brief, Strengthening Health and Opportunities for All Americans," U.S. Department of Health and Human Services, *available at* http://www.hhs.gov/budget/budget-brief-fy2013.pdf

raising serious market power concerns. The movement towards payment based on value also should further a market for analytic tools to measure quality and efficiency that would help address one of the major market failures that has plagued health care. Under ACO-like arrangements, physicians will use these tools to choose the facilities where they wish to practice and to shift care among themselves so as to reduce overall costs and improve quality scores.

PPACA, and ongoing discussions about reducing the deficit, also have prompted concerns among the provider community about the reductions in Medicare reimbursement generally. For example, Medicare on the average paid only 95 percent of hospital costs in 2009, compared to 112 percent in 1997.[10] With respect to physicians, payments under the Medicare fee schedule in 2010 averaged only 81 percent of private insurer payments for preferred provider organizations across all physician services and geographic areas.[11]

Concern about large Medicare cuts is prompting some physicians to sell their practices and seek employment by larger health care systems or with much larger physician practices. Similarly, such concerns have caused some health care systems to consolidate so they can have greater access to capital, obtain more financial stability, and reduce costs. Health plans and some observers have asserted that, in addition to these beneficial results, the consolidations also can result in greater market power (or at least "clout") in dealing with commercial health plans, and the result will be higher commercial health plan negotiated rates; and such increased rates may go to subsidizing shortfalls from Medicare, Medicaid, and other government payers.[12]

IV. TOUGH ISSUES FOR ANTITRUST ENFORCERS

The developments discussed above mean that the healthcare landscape—already a complex one for antitrust enforcement—will likely become even more challenging.

Undoubtedly antitrust enforcers will continue to do what they are doing now—scrutinize provider mergers—both hospitals and physicians—and challenge those that they believe result in undue concentration in well-defined markets with high entry barriers, and which will likely have anticompetitive effects. The most obvious targets are mergers in moderate-sized cities in relatively isolated areas. These will have sufficient population for the agencies to argue that there is enough volume to support the efficient continued operation of the merging providers as independent entities, and where the geographic market for at least a substantial range of services seems well-defined and limited. The recent FTC hospital challenges in Toledo, Ohio; Rockford, Illinois; and Albany, Georgia are examples.

But such matters involve a small percentage of the health care sector. As they branch further afield, antitrust enforcers will face a number of much more difficult issues to assess. These include the following:

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[10] Hospital margins under Medicare vary widely, based on location, teaching status, patient mix, and other factors. *See* MedPAC 2011 Data Book at 77.

[11] *See* "Report to the Congress, Medicare Payment Policy," Medical Payment Advisory Commission, March 2010, at 105-06, *available at* http://www.medpac.gov/documents/Mar12_EntireReport.pdf. .

[12] *See e.g.* Berenson, Ginsburg, Christianson, & Yee, *The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed*, 31(5) HEALTH AFFAIRS 973 (May 2012) *available at* http://content.healthaffairs.org/content/31/5/973.abstract; Havighurst & Richman, *supra* n. 3.

- *Hospital mergers in urban areas***.** The Antitrust Division was unsuccessful in its 1997 challenge of the merger of the North Shore Health System and Long Island Jewish Medical Center, as the court rejected the Division's allegation of an "anchor hospital" product market and found that the merging hospitals competed with numerous other hospitals in Long Island and parts of New York City.[13] The FTC took a different approach in the Evanston Northwestern/Highland Park Hospital merger, where the Commission ultimately found a geographic market that consisted essentially of just the merging hospitals, notwithstanding the presence of close to 100 hospitals in the Chicago area.[14] But that challenge was based primarily on evidence of anticompetitive effects that had occurred since the merger had closed. Given the length of time needed to obtain such evidence and to litigate a case, the agencies may conclude that because such delays may preclude meaningful relief, absent very unusual circumstances, retrospective challenges are not worth bringing. This means that the agencies, if they wish to mount hospital merger challenges in large urban areas, will need to develop persuasive evidence regarding likely competitive effects, notwithstanding the likely presence of other nearby hospitals.
- *Physician mergers*. The antitrust enforcers have investigated a number of physician mergers, and in recent years have challenged a few, although none have gone to litigation. This likely will become an area of increasing concern as physicians form large single-specialty practices, or hospital systems acquire a large share of physicians in the same specialty. These cases could raise challenging questions regarding geographic and perhaps product market definition, as well as the extent of entry barriers. Because they are likely not to be HSR-reportable, many of these investigations will likely arise post-closing, perhaps in response to efforts by the merged entity to obtain substantial increases in negotiated rates. One response may be that even if rates went up, so did quality and value (i.e. lower unnecessary utilization). Determining whether indeed there has been an increase in "quality-adjusted prices" (or perhaps alternatively total expenditures for a given population over time, taking into account appropriate adjustments) will be a crucial, and difficult, issue.
- *"Cross-market" and vertical mergers*. Many health systems are expanding by acquiring hospitals outside of their service areas, or complementary providers, such as physicians, laboratories, home health agencies, and other entities that do not compete for hospital inpatients. Health plans assert that such acquisitions give the system more bargaining clout and that, after the transaction, the acquired provider often obtains higher rates, and the whole system—which may negotiate on a "take it or leave it all" basis—is able to negotiate more generous rate increases. There may be legitimate reasons for higher post-acquisition rates (*e.g.* an increase in quality or the use of more skilled negotiators). But even absent such reasons the agencies will face a substantial burden in challenging mergers of entities that do not compete in the same market. Similarly, the agencies likely

[13] *See U.S. v. Long Island Jewish Medical Center and North Shore Health System Inc.*, 983 F.Supp. 121, 137-140 (E.D. NY 1997).

[14] *See In the Matter of Evanston Northwestern Healthcare Corporation*, F.T.C. No. 9315, at 63-64 (Aug. 2, 2007), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.

will face a high burden if they seek to challenge contracting practices involving tying or bundling unless the system has market power and likely anticompetitive effects can be shown.

- *ACO formation and operation*. As I have described elsewhere,[15] with the publication of the ACO regulations and the DOJ/FTC statement of antitrust enforcement policy regarding ACOs,[16] providers should have a more clearly defined path regarding how to achieve sufficient financial and/or clinical integration to avoid *per se* condemnation. While there still may be some providers who merely wish to jointly negotiate their fees with no real intention of implementing meaningful processes to improve quality or reduce costs, most provider collaborations will involve genuine efforts to improve their so-called "value proposition." Many of these will not involve sufficient horizontal overlaps to raise serious antitrust concerns. But others may raise issues, particularly where they involve dominant hospitals or "must have" physician groups. Conduct that likely will be scrutinized will raise issues of both potential collusion (*i.e.* involving too large a share of competing providers), as well as foreclosure and exclusion (*i.e.* making it difficult for competitors to form their own ACOs or otherwise compete). Here the Agencies will be faced with difficult, and novel, questions, as they seek to weigh potential adverse effects that likely will be felt primarily in the commercial market (at least with respect to an impact on prices), against the potential for improved care and efficiencies for patients covered by both commercial and government payers.
- *Conduct that prevents health plans from using tiering/steering approaches or disseminating information about provider cost and quality*. Given the preference that consumers have for broad provider networks, many health plans report that they cannot successfully market networks without certain "must have" providers. But plans can promote intra-network competition by using benefit designs that incentivize health plan members to use providers that are lower cost or higher quality—provided that such information is available and the providers do not preclude tiering or steering approaches. While such initiatives have not been widely used by health plans in the past, there is growing interest in them. There may be, of course, legitimate reasons why a provider may oppose the use of tiering or steering, or certain information dissemination—for example, if it involves the use of misleading or inaccurate data. Moreover, is also not clear that a provider's insistence that it not be disadvantaged under a steering or tiering approach, by itself, would violate the antitrust laws.

The above list is not exhaustive. And, as noted, some of the conduct which arguably may frustrate efforts to make health care markets more competitive may be difficult or even impossible to challenge successfully under the antitrust laws. It is here that policymakers may conclude that it is necessary to adopt an approach that combines antitrust insight in how

[15] Leibenluft, *The ACO Antitrust Policy Statement: Antitrust Enforcement Meets Regulatory Rulemaking,* ANTITRUST SOURCE (December 2011) *available at* http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/dec11_leibenluft_12_21f.pdf.

[16] *See* Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011), *available at* http://www.ftc.gov/os/fedreg/2011/10/111020aco.pdf.

competitive markets should function with the tools that can be provided only through a regulatory regime. Indeed, the proposed ACO guidelines can be seen as an example of that approach. Under the proposed guidelines, all MSSP ACOs that met certain thresholds would have been subject to mandatory review.[17]

Had this aspect of the proposal been adopted, ACOs that included dominant providers might have found it difficult to survive that mandatory review if they engaged in certain conduct that the agencies indicated should be avoided. These included preventing or discouraging steering or tiering, requiring a purchaser to contract with all hospitals under common ownership, and restricting payers from making available to their enrollees information about providers' cost, quality, efficiency, and performance. In short, the antitrust agencies proposed to use a regulatory "hook" to effectively prevent certain practices that they might have had difficulty challenging as antitrust violations. The final ACO guidelines retain many of these provisions, but in a less restrictive form that does not include any mandatory review.

V. CONCLUSION

Health care antitrust enforcement has never been simple. But if the movement towards consolidation and integration continues, the antitrust agencies will need to address an even more challenging array of issues. This may result in novel challenges in the courts, and also greater coordination between antitrust enforcers and the Centers for Medicare and Medicaid Services and other government agencies to consider how to make health care markets more competitive through regulatory interventions.

[17] *See* Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 21,894, 21,897-98 (Apr. 19, 2011), *available at* http://www.justice.gov/os/fedreg/2011/03/110331acofrn.pdf.