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Concentration in Health Care Markets: Chronic Problems and Better Solutions

Barak D. Richman

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Editor's Note

All types of monopoly are not created equal in the US economy. In this study, Barak Richman of Duke University Law School emphasizes that health care providers with market power enjoy substantially more pricing freedom than monopolists in other markets.

Though problems of excessive concentration and insufficient competition in health care markets are not new, markets for hospital services have recently presented the most serious competition policy issues. Traditional antitrust enforcement tools have done little to halt the extraordinary consolidation in local hospital markets over the last two decades, which has driven higher price increases for inpatient services. Comprehensive, US-style health insurance further enhances the pricing freedom of health care firms with market power.

The Patient Protection and Affordable Care Act of 2010 (PPACA) does little to address the monopoly problem and may even worsen it. The highly regulated and heavily subsidized regime ahead under the PPACA already has triggered a feverish scramble among health industry firms (insurers, pharmaceutical manufacturers, physician practice groups, and device makers, as well as hospitals) to get bigger market share and also become better connected politically to ensure that they will be among the politically dependent survivor incumbents in the years ahead. With most of the key decisions in health care financing, coverage, and even treatment likely to be made in Washington, investments in winning future rounds of political competition are likely to trump responsiveness to market competition.

The PPACA poses some additional barriers to more vigorous competition in health services. Its "minimum medical loss ratio" rules for insurers may superficially appeal to some insurance purchasers but could further disarm payers in aggressive price negotiations with providers and stifle insurers' investments in innovative monitoring and improvement of health care delivery. The eventual scope and scale of the act's regulatory requirements for "essential health benefits" also could discourage investments in low-cost, nonmedical alternative interventions that can produce results superior to mandated traditional care.

Richman observes that whereas monopolies in other parts of the economy enable sellers to charge higher prices while reducing output, comprehensive third-party health insurance coverage enables many cost-insensitive patients to pay monopolist providers' asking prices rather than being induced to give up desirable health care goods and services. This means "too much of a good thing," at excessive prices. The combination of market concentration and generous insurance means consumers and providers end up overspending even more on costly health care.

We need better solutions to this chronic problem of too much concentration and too little competition,

including not just tighter review of new hospital mergers and consolidations but also

- Closer monitoring of the competitive effects of emerging affordable care organizations;
- Curbing new abuses of "state action" immunity;
- Requiring unbundling of monopolized health care services;
- Challenging anticompetitive terms in insurer-provider contracts;
- Promoting interregional competition in health care services; and
- Encouraging nonmedical substitutes for "essential" health benefits.

Richman looks at each of these solutions in detail in this thought-provoking paper.

Instead of doubling down on the "metabolic disorder" triggered by public policies that encourage overconsumption of conventional, highly subsidized health insurance—or resorting to tighter price controls and public utility–style regulation of politically mandated coverage, we should consider some better remedial medicine—a stronger dose of market competition.

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Executive Summary

Health care providers with market power enjoy substantially more pricing freedom than monopolists in other markets, for a reason not generally recognized: US-style health insurance. Consequently, monopolies in health care cause undesirable redistribution of wealth and inefficient allocation of resources, both of which burden consumers at levels beyond those of other monopolists.

The unusual costliness of monopoly power in health care markets demands far more policy attention than it has received. For starters, the health sector needs a more aggressive antitrust policy that effectively prevents the creation of new provider market power through mergers, alliances, or government immunity. An immediate need is ensuring that the formation of accountable care organizations under the Patient Protection and Affordable Care Act (PPACA), which in theory might achieve efficiencies through vertical integrations, do not primarily lead to horizontal integrations that give providers additional market power.

However, because antitrust policy has been so inadequate for so long in the health sector, and because it remains unlikely that courts or enforcement agencies will undo past mergers that created these powerful provider monopolies, policymakers should pursue additional strategies for contesting existing monopolies. One approach is to apply antitrust rules against "tying" arrangements so that 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 "antisteering" or "most-favored-nation" clauses, in provider-insurer contracts. Policymakers could also help restore price competition in monopolized markets by enabling private payers to negotiate prices for specific provider services and encouraging insurers to expand the scope of competition—via medical tourism, for example, or configuring innovative health care delivery that bypasses many of the embedded costs in the current system.

Some commentators have suggested that the provider monopoly problem is severe enough to warrant consideration of a more radical alternative: regulating provider prices. By restricting how insurers can purchase health services, the PPACA might effectuate a regulatory regime that significantly limits price and nonprice competition. However, even under the PPACA room remains for creative regulatory policies that enhance competition in health care markets and encourage better uses of our increasingly scarce health care dollars.

Concentration in Health Care Markets: Chronic Problems and Better Solutions

Introduction

Health care providers and suppliers with monopoly power impose enormous costs on both private and public budgets, yet their distortions on the US marketplace have avoided sorely needed scrutiny and redress.[1] In fact, many policymakers and commentators have taken a benign view of health care monopolies, suggesting that they serve important public purposes and thus should receive favorable treatment from antitrust rules designed to require competition. The truth is, however, that health care monopolies—for-profit and nonprofit alike—are more, not just equally, harmful to both consumers and the general welfare than monopolies of other kinds. They lead to higher prices, create greater inefficiencies, and cause larger economic rents from favorable regulatory treatment than even typical monopolists. They impose economic costs that simply are not sustainable.

The main culprit responsible for making health care monopolies so costly is health insurance—at least, the kind that covers most Americans—and the rules, regulations, and customs that shape its provision in US markets. Certain features of US-style health insurance greatly enhance the pricing freedom of health care firms with market power, producing much larger monopoly profits and much greater redistribution of wealth than would result from monopoly power in markets where consumers face prices directly. US-style health insurance also fosters serious inefficiencies in resource allocation, albeit not the kind of misallocation that economic theory normally associates with the exercise of monopoly power.[2]

These distortive consequences of combining monopoly power with US-style health insurance will only amplify after the Patient Protection and Affordable Care Act (PPACA), enacted by Congress in 2010, expands the ranks of the insured. The PPACA not only does little to address the current monopoly problem but will even add substantially to providers' and suppliers' profits by increasing the pervasiveness of US-style insurance. Indeed, many elements in the PPACA restrict the freedom of third-party purchasers to choose less expensive coverage and limit variation in insurance products, which will further enshrine the harmful features of US-style insurance that magnify the costs of monopoly power. Unless a more effective competition policy can be implemented in the health sector, many millions of additional Americans will soon carry exactly the kind of health coverage that currently serves provider and supplier monopolists so well. If anything, the PPACA makes a strong antimonopoly policy in health care even more imperative.

One initial policy recommendation is that mergers, consolidations, and other potentially monopolistic

practices of health care providers—including the very recent wave of efforts to consolidate market power around so-called accountable care organizations (ACOs)—should be subject to special, not relaxed, vigilance by antitrust agencies and courts. But because antitrust policy has for too long permitted health care monopolies to grow in many markets, we need other policy initiatives to mitigate the harm from already-concentrated provider markets. Policymakers, therefore, should scrutinize whether current health care monopolists are seeking to illegally exploit, expand, or enshrine their market power. Common practices such as bundling services, demanding exclusive dealings with insurers, and restricting price shopping should invite rigorous antitrust attention. Policymakers could also help restore price competition in monopolized markets by enabling private payers to negotiate prices for specific provider services and encouraging insurers to expand the scope of competition—via medical tourism, for example, or configuring innovative health care delivery that bypasses many of the embedded costs in the current system.

Certain features of US-style health insurance greatly enhance the pricing freedom of health care firms with market power.

Despite its great economic costs and consequences, the potency of this combination of monopoly power and the US-style insurance system has gone largely unnoticed by the antitrust agencies and economists. It is additionally troubling that Congress largely ignored these severely detrimental aspects of the American system of financing health care, including its potential to further enrich industry monopolists and impose unbearable inefficiencies, when deliberating and enacting the PPACA.

Nonetheless, policymakers and industry leaders still can avail themselves of several tools to infuse competition into health care markets. The case for a more rigorous competition policy in the health care sector is significantly stronger than even its advocates have generally appreciated. Despite past failure to recognize fully the dangers of health care monopolies, today's innovative payers, nonmonopolist providers, and policymakers can exert sufficient competitive pressures to begin controlling costs and bringing value to premium payers.

How Health Insurance Compounds the Harms of Provider Monopoly

The past several decades have witnessed extraordinary consolidation in local hospital markets, with a particularly aggressive merger wave occurring in the 1990s. By 1995, hospital merger and acquisition activity was nine times its level at the start of the decade, and by 2003, almost 90 percent of Americans living in the nation's larger metropolitan statistical areas (MSAs) faced highly concentrated provider markets.[3] This wave of hospital consolidation, predictably, was alone responsible for price increases for inpatient services of "at least five percent and likely significantly more," and similarly responsible for price increases of 40 percent where merging hospitals are closely located.[4] A second merger wave from 2006 to 2009 significantly increased the hospital concentration in thirty MSAs,[5] and the vast majority of Americans are now subject to monopoly power in their local hospital markets.

In economic theory, monopolies are objectionable because they enable sellers to charge higher prices and thereby cause some consumers (who would be willing to pay a competitive price) to forgo enjoyment of the monopolized good or service. Fortunately, such output-reducing effects are greatly lessened in health care markets because the many patients covered by health insurance can easily pay monopolist providers' asking prices rather than being induced to give up these desirable goods and services. But unfortunately, precisely because there is no output reduction in response to monopoly price increases, health insurance both amplifies the redistributive effects of provider and supplier monopolies

and inflicts allocative inefficiencies that are arguably more distortive and costly than those caused by typical monopolists.

Supra-Monopoly Pricing. In the textbook model, a monopoly redistributes wealth from consumers to powerful firms. The monopolist's higher price enables it to capture for itself much of the welfare gain, or "surplus," consumers would have enjoyed if they had been able to purchase the valued good or service at a lower competitive price. In health care, insurance puts the monopolist in an even stronger position because consumers do not face, and therefore are not deterred by, monopoly prices. This effect appears in theory as a steepened demand curve for the monopolized good or service. Whereas most monopolists encounter reduced demand with each price increase, health insurance mutes the marginal consequences of rising prices.

If health insurers perfectly represented their subscribers' preferences, their policies would reflect consumers' demand curves and pay for services at prices that individual insureds would, absent insurance, be willing to pay themselves. But deficiencies in the design and administration of real-world health insurance prevent insurers from reproducing their insureds' preferences and thus heavily magnify monopoly power. For legal, regulatory, and other reasons, health insurers in the United States are in no position (as consumers themselves would be) to refuse to pay a provider's high price even if 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 deemed advantageous (and termed "medically necessary" under rather generous legal standards) for the patient's health, whatever the cost.[6]

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

Thus, health insurance enables a monopolist of a covered service to charge substantially more than the textbook "monopoly price," thereby earning even more than the usual "monopoly profit." The magnitude of the monopoly-plus-insurance distortion has sometimes surprised even its beneficiaries.[7] Of course, since third-party payers (and not patients) are covering the interim bill, these extraordinary profits made possible by health insurance are earned at the expense of those bearing the cost of insurance. Insureds, even when their employers are the direct purchasers of health insurance, are ultimately the ones seeing their take-home pay shrink from hikes in insurance premiums caused by provider monopolies.

Discussions of antitrust issues in the health care sector rarely, if ever, explicitly observe how health insurance in general, or US-style insurance in particular, enhances dominant sellers' ability to exploit consumers. Although scholars have previously observed that prices for health services are much higher in the United States than in other Organisation for Economic Co-operation and Development (OECD) nations (without observable differences in quality),[8] and although many have observed that provider market power has been a significant factor in inflating those prices,[9] few have observed the synergistic effects of monopoly and health insurance.

Perhaps more notably, despite the huge implications for consumers and the general welfare, the special redistributive effects of monopoly in health care markets are not mentioned in the antitrust agencies' definitive statements of enforcement policy in the health care sector.[10] 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 millions of additional consumers if monopolists of health care services and products can continue

to charge not what consumers would prefer to bear but instead what insurers, because of severe market failures, are required to bear.[11]

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

Even in the absence of monopoly, conventional health insurance enables consumers and providers to overspend on 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 the unavoidable price 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. US-style health insurance, therefore, is constrained in limiting the allocative inefficiencies from moral hazard. Although uncontrolled moral hazard is a problem throughout the health sector, combining inefficiently designed insurance with provider monopolies compounds the economic harm.

The extraordinary profitability of health-sector monopolies also introduces a dynamic source of resource misallocation by intensifying firms' usual inducement to seek market dominance. The introductions of new technologies have been a primary source of health care cost increases over the past several decades—responsible for as much as 40–50 percent.[12] And even though many innovations offer only marginal value, their monopoly power under intellectual property laws secure lucrative payments from insurers whose hands are tied. Although many have recognized that new technologies are a principal source of unsustainable increases in health care costs, and several others have recognized how the moral hazard of insurance has both fueled technology-driven cost increases and distorted innovation incentives (toward cost-increasing innovations at the expense of cost-reducing innovations),[13] few have recognized that this is a general problem with combining monopoly with insurance rather than a generic inefficiency from moral hazard.

The extraordinary profitability of health-sector monopolies introduces a dynamic source of resource misallocation by intensifying firms' usual inducement to seek market dominance.

Provider monopolies also inflict economic harm by spending heavily to sustain current monopoly barriers. Indeed, Richard Posner has theorized that a monopoly's most serious misallocative effect is not the output reduction recognized in theoretical models but instead the monopolist's strenuous efforts to obtain, defend, and extend market power.[14] This is especially true for health care monopolists because so many are maintained with legal and regulatory barriers—certificate-of-need laws, licensure requirements, and regulations restricting limitations on provider networks, for example. Thus, health care monopolists are willing to spend heavily (up to the private value of the monopoly) on legal and political resources that impede competition. This contrasts starkly with the narrative in which we reward monopolies (with monopoly profits) for their investing in the "superior skill, foresight, and industry" that creates social value.[15]

Mergers of all kinds deserve serious scrutiny from antitrust enforcers because they often amount to an easy and unjustified shortcut to gaining market power. Although proponents of consolidations in health care provider markets usually tout anticipated

efficiencies from combining and rationalizing operations, such efficiencies are seldom identified with precision, and the opportunity to increase their bargaining power vis-à-vis private payers appears to be the far likelier explanation for all such mergers in concentrated health care markets.[16]

In light of the disproportionately large share of national resources already being spent on health care in the United States compared to every other nation in the world,[17] the enormous burden of distortive health-sector monopolies provide compelling, even alarming, reasons to apply the antitrust laws with particular force against health care providers and suppliers with market power. If antitrust enforcement is not up to the task of restoring competition in markets where it is lacking, political actors may resort instead to regulatory measures of mixed economic wisdom.

The Problem of Nonprofit Hospitals. Nonprofit hospitals remain the primary provider of the nation's hospital care, responsible for 73 percent of admissions, 76 percent of outpatient visits, and 75 percent of hospital expenditures.[18] Yet ever since the antitrust laws were first applied systematically in the health care sector in the mid-1970s, some judges and scholars have resisted giving the statutory policy of fostering competition its due in health care settings, especially in cases involving nonprofit hospitals. Between 1995 and 2000, for example, antitrust enforcers encountered sustained judicial resistance when challenging mergers of nonprofit hospitals and suffered a six-case losing streak in such cases in the federal courts.[19]

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.[20] The government has more recently won back some of the legal ground it lost,[21] but its inability to apply antitrust law rigorously and systematically in the big business that health care has become is one important reason why many health care markets are now dominated by firms with alarming pricing power.[22]

One source of judicial resistance to antitrust enforcement in these cases—and a source of protection for would-be nonprofit hospital monopolists—was the belief, espoused by some vocal academics, that nonprofit hospitals do not exploit monopoly power they might enjoy. This view is now widely discredited, with abundant empirical evidence reporting that nonprofit hospitals do, as economic theory would predict, take advantage of their pricing power.[23]

Moreover, as the previous section of this report makes clear, this wrangling over whether nonprofit monopolists are less likely to behave worse than for-profit ones severely missed the most important theoretical concerns and empirical evidence. While researchers fretted over whether organizational form influenced pricing policies, they did not recognize the overwhelming danger of combining hospital monopolies—for-profit and nonprofit alike—with US-style insurance.

A second source of judicial resistance to antitrust enforcement has been the implicit, and often explicit, belief harbored by many judges that nonprofit hospitals monopolists would put to good use any market power they might possess.[24] Great reason exists to question this judicial presumption as well. 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 exercise of market power by nonprofit hospitals generally shifts wealth from richer individuals to poorer ones, rather than the opposite, 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 anticompetitively to direct their limited scholarship funds toward lower-income students.[25] One easily senses in hospital merger cases a similar judicial dispensation in favor of nonprofit enterprises that raise prices for seemingly progressive purposes.

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. A controversial ruling by the Internal Revenue Service interpreted the Revenue Code's charitable-purposes requirement very broadly, allowing hospitals to maintain tax-exempt status if they expend untaxed surpluses on anything that arguably "promotes health."[26] This includes much more than just caring for the indigent. In fact, that ruling (which relaxed 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"[27]) came when the Medicare and Medicaid programs were relatively new and private health insurance was expanding. Certainly the pervasiveness of public and private insurance, particularly if the PPACA is fully implemented, undermines the primary rationale behind encouraging nonprofit hospitals to be charitable in the original sense. Moreover, federal, state, and local governments separately and substantially subsidize nonprofit hospitals' most clearly charitable activities, through both special tax exemptions and direct financial assistance. Thus, activities that were provided originally in exchange for tax-exempt status are now largely paid for through direct government tax subsidies or insurance payments.

In fact, 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.[28] Such hospitals can usually qualify for exemptions merely by spending their surpluses on medical research; training various types of health care personnel; or, most important, acquiring state-of-the-art facilities and equipment, which (ironically) can also secure and enhance their market dominance. Many of these activities confer significant benefits on interest groups and individuals that are relatively high on the income scale. To be sure, most of the activities and projects financed from hospital surpluses are hard to criticize in the abstract. But many of them are not so obviously progressive in their redistributive effects (or otherwise so obviously worthy of public support) that antitrust prohibitions should be relaxed so hospitals can finance more of them.

These minimal requirements for tax exemption provide no assurance that nonprofit hospital monopolists are spending their extraordinary surpluses 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. To the contrary, managers of nonprofit firms have incentives to maintain monopolies to fund the construction and expansion of empires that enhance their self-esteem and professional influence. Such empire building is most easily accomplished by obtaining market power and using it to generate surpluses with which to further entrench and extend a firm's dominance.

For several decades, ever since private insurance, Medicare, and Medicaid substantially reduced hospitals' charitable burdens and began to pour new resources into health care, nonprofit monopolies have been channeling funds into health care uses that, other than being labeled "charitable" for tax purposes, have never been reliably legitimized as priorities by either market or political processes. In fact, overproduction and overconsumption of health services is currently an arguably bigger problem than scarcity. Therefore, permitting nonprofits to accumulate monopoly power to subsidize the provision of additional health services exacerbates, not solves, the nation's health care crisis. In the aftermath of a deep recession, policies that increase 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.

A Head Tax. The bulk of the financial responsibility to sustain providers' supra monopoly pricing, excess output, and "charitable" activities ultimately falls more or less equally on individuals bearing the cost of health insurance premiums. To be sure, local and federal taxpayers pick up part of the bill through subsidies, entitlement programs, assorted multipliers in Medicare reimbursement, and the like. But the lion's share of this financial burden falls on private premium payers in a manner that closely resembles 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 regressive and unfair than this. Those who take a benign view of the seemingly good works of health care providers should focus more attention on who (ultimately) pays for and who benefits from those nominally charitable activities.[29]

The regressive redistributive effects of nonprofit hospitals' monopolies appear never to have been given due weight in antitrust appraisals of hospital mergers.[30] To be sure, pure economic theory withholds judgment on the rightness or wrongness of redistributing income because economists have no objective basis for preferring one distribution of wealth over another. But the antitrust laws principally enjoy general political support because the consuming public resents the idea of illegitimate monopolists enriching themselves at the public's expense.[31]

In sum, certain judges' sanguine attitude toward nonprofit monopolies has contributed to what now is a crisis in provider markets. The ubiquity of nonprofit hospitals with market power now constitutes a significant source of the provider monopoly problem in health care. Recognizing the extraordinary pricing freedom that US-style health insurance confers on monopolist providers, along with the magnified losses in efficiency and distributional equity that such pricing freedom causes, one can conclude only that these judicial sympathies played significant roles in what can only be described as a colossal failure of antitrust enforcement.

A New Antitrust Agenda?

Can government, through antitrust enforcement or otherwise, do anything about the problem of provider and supplier market power in health care markets? Although the enforcement agencies and courts should certainly scrutinize new hospital mergers and similar consolidations with greater skepticism, preventing new mergers cannot correct past failures to maintain competition in hospital and other markets. Enforcers may challenge the legality of previously consummated mergers, as the Federal Trade Commission (FTC) did in the *Evanston Northwestern* case, but practical and judicial difficulties in fashioning a remedy make it difficult to 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.[32] Although the FTC might seek more substantial relief to unwind other mergers-to-monopoly, the general rule seems to be that old, unlawful mergers are amenable to later breakup only in the unusual case when the component parts have not been significantly integrated.[33]

In any case, given their past skepticism about antitrust enforcement in health care markets,[34] courts would be hard to enlist in an antitrust campaign to roll back earlier consolidations. Thus, a policy agenda capable of redressing the provider monopoly problem in health care will need to employ other legal and regulatory instruments. A first order of business would be to fastidiously prevent the formation of new provider monopolies, since health care providers continue to seek opportunities to consolidate—through the recent wave of ACOs, in particular. Moreover, health care providers are seeking to consummate mergers by claiming, through questionable legal arguments, immunity from the antitrust laws. Finally, an array of other enforcement policies can target monopolists behaving badly—those trying to either expand their monopoly power into currently competitive markets or foreclose their market to possible entrants. Thus, several fronts remain available for policymakers to wage antitrust battles. A new antitrust agenda begins with recognizing the extraordinary costs to health care provider monopolies and continues with aggressive and creative antimonopoly interventions.

The Special Problem of Accountable Care Organizations. A primary target for a revived antitrust agenda is the emerging ACOs, whose development the PPACA is designed to stimulate. The PPACA encourages providers to integrate themselves in ACOs

for the purpose of implementing "best practices" and thereby providing high-quality coordinated care at a low cost. To induce providers to form and practice within these presumptively more efficient entities, the PPACA and its implementing regulations instruct the Medicare program to share with an ACO any cost savings it can demonstrate, permitting proposed ACOs either to keep any savings beyond a minimum savings rate (MSR) of up to 3.9 percent while being insured against losses or to keep savings beyond an MSR of 2 percent while being exposed to the risk of losses.[35] ACOs are being hailed as a meaningful opportunity to reform our deeply inefficient delivery system, but promising health policy initiatives often lead to disappointing projects and unintended consequences. One serious risk in forming ACOs is that they may create even more aggregation of pricing power in the hands of providers.

ACOs, in theory, could offer an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery system.[36] Together with good information systems and compensation arrangements, vertical integration of complementary health care entities can achieve important efficiencies by reducing medical errors, eliminating duplicative services and facilities, and coordinating elements needed to deliver high-quality, patient-centered care.[37]

Skeptics, who include FTC Commissioner Thomas Rosch, note that "available evidence suggests that the cost savings [from ACOs] will be very small to nonexistent" and warn that any purported reductions in expenditures "will simply be shifted to payors in the commercial sector."[38] Others have warned that efforts to replicate early successes in integrated delivery systems—which serve as models for reformers' aspirations—have often failed, partly because many physicians are reluctant to forgo the lucrative possibilities of unconstrained fee-for-service practice and partly because physicians who do integrate with hospital systems predictably resist adhering to efficiency-enhancing management. Moreover, many ACOs are reportedly being sponsored by hospitals, which any efficient delivery system would use sparingly. Hospital investments might be designed to preempt control of ACOs, rather than harness their potential efficiencies, so any cost savings would come at the expense of others.

In contrast to the varying views on their potential benefits, there is widespread agreement that ACOs could engineer and leverage greater monopoly power in an already-concentrated health care market.[39] Organizers of ACOs are forging collaborations among entire markets of physicians and hospitals, entities that would otherwise compete with one another. 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."[40] In fact, providers' main purpose in forming ACOs may not be to achieve cost savings to share with Medicare but to strengthen their market power over purchasers in the private sector. ACOs "may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations."[41]

Permitting nonprofits to accumulate monopoly power to subsidize the provision of additional health services exacerbates, not solves, the nation's health care crisis.

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

especially stringent anticoncentration, antimerger policy in the health care sector. These heightened dangers should be weighed heavily in appraising an ACO's likely market impact.

It remains to be seen whether the FTC and Department of Justice (DOJ) will have the opportunity to apply this necessary level of scrutiny. The revised rules, released by the Centers for Medicare and Medicaid Services (CMS) in November 2011 to implement the ACOs "Shared Savings Plan," indicate that the antitrust agencies will apply the Rule of Reason to determine whether a proposed ACO will violate the Sherman Act, and proposals in which an ACO's independent participants have low shares within a relevant market can fall within a "safety zone" to evade scrutiny altogether. Moreover, unlike the proposed rules in March 2011, antitrust review will not be mandatory for proposed ACOs.

This leaves the implementing agencies with a great deal of discretion—and keeps their feet far from the proverbial fire—in ensuring that an ACO complies with the principles of competition. The agencies could demand a heightened showing that a proposed consolidation will generate identifiable efficiencies, and they similarly might demand that an ACO's proponents assume the burden of showing an absence of significant horizontal effects in local submarket. The agencies could also impose demanding structural remedies to illegal concentrations, perhaps encouraging the vertical integration envisioned by the PPACA's proponents while *reducing* the horizontal collaboration that providers so routinely pursue. Finally, the agencies could impose conduct (nonstructural) remedies to potentially harmful ACOs, such as requiring nonexclusive contractual arrangements with payers and, especially, with regional hospitals. How the FTC and DOJ monitor the formation of ACOs could determine whether the PPACA meaningfully advances a (desperately needed) reorganization of health care delivery or merely offers a loophole to permit greater consolidation.

The CMS might also fill an independent role in meaningfully preventing ACOs from furthering anticompetitive harm in health care marketplaces. The final rules permit the CMS to share savings with ACOs only after they meet quality benchmarks, which the CMS administrators ought to take seriously.[42] The rules also require cost and quality reporting, and the CMS might require a demonstration of meaningful quality improvements and cost savings to receive a continued share of Medicare savings. The CMS might even condition an ACO's permission to market to private payers on its demonstration that its prices to private payers did not increase significantly following its formation.

One might wonder, of course, whether a governmental single payer like Medicare has the mission, impulse, or requisite creativity to foster competitive private markets for health services. Perhaps the CMS's new Center for Medicare and Medicaid Innovation could shape the institution's capacity to affect reform. It might be equally likely, unfortunately, that Medicare will aim to preserve its own solvency by encouraging the shifting of costs to the private sector—and it may even reward ACOs' cost shifting as cost savings.[43] This is the danger with using a large and unavoidably inflexible bureaucracy to engineer an effort to induce innovation. Nonetheless, you go to war with the bureaucracy you have, and the CMS should concentrate its substantial resources on developing competition-oriented regulations that cautiously monitor the market impact of emerging ACOs.

Challenging "State Action" Immunity. A common subplot in antitrust law has cartels or monopolists avoid liability by obtaining sanction from a state or local government. The "state action immunity" doctrine permits states to regulate and even authorize anticompetitive conduct, provided that (1) there is a clearly articulated policy designed to displace competition, and (2) the state actively supervises the conduct under the regulatory scheme.[44] The upshot is that states can, if they so choose, immunize anticompetitive conduct from Sherman Act liability. Predictable beneficiaries of state protection have included a statewide collaboration of raisin growers,[45] regional motor carriers seeking to set common rates,[46] and a town's politically powerful billboard monopolist.[47]

The doctrine's parameters, which turn on what constitutes a "clear articulation" and "active supervision,"

are notoriously limber.[48] Nonetheless, recent efforts by health care providers to invoke the doctrine have pushed the outer bounds of reason.[49] Perhaps the profitability of health care monopolies has encouraged providers to develop new, previously ridiculed legal arguments that would protect their market dominance from prosecution. In any event, the growing popularity of invoking state action immunity, and the breadth of those invocations, needs to be stopped in its tracks, as the last thing either antitrust law or health policy needs is immunity for health care monopolists. Limiting the scope of state action immunity might be the next battlefront in antitrust enforcement in the health sector.

Three recent efforts to expand state action immunity are now unfolding (unsurprisingly, all involving the health care industry):

1. In Michigan, the DOJ is suing the state's BlueCross BlueShield for engaging in anticompetitive agreements with the state's dominant provider.[50] BlueCross claimed that it is immune from the Sherman Act because "Michigan created Blue Cross Pursuant to a Comprehensive Health Care Regulatory Scheme."[51]

2. In North Carolina, the state's Board of Dental Examiners has attracted FTC scrutiny in its efforts to block nondentists in the state from providing teeth-whitening goods or services.[52] The board sued to block the FTC proceeding, claiming that it is "an agency of the sovereign State of North Carolina" and thus is beyond the FTC's prosecution.[53]

3. Parties pursuing a merger of two hospitals in Albany-Dougherty County, Georgia—a merger that would unquestionably create a monopoly—have claimed immunity from an FTC challenge because the county's Hospital Authority nominally owns the acquiring hospital and thus would own the monopoly.[54]

Each of these immunity claims stands on extremely shaky logic. When Michigan, like all states, enacted a comprehensive regulatory scheme, it issued no clear articulation that the regulatory structure would encourage or condone anticompetitive contracting. Although North Carolina ostensibly authorized the Board of Dental Examiners to engage in some self-governance, it did not give the board exclusive control over economic activity that requires no dental expertise. And the Albany-Dougherty County Hospital Authority's offering of a sham cover for a merger-to-monopoly is neither consistent with articulated Georgia policy nor actively supervised by state policymakers. The proper scope of the state action immunity doctrine immunizes none of this anticompetitive conduct.

The district court in Michigan appropriately rejected BlueCross's immunity claim, and the Sixth Circuit affirmed that ruling following BlueCross's interlocutory appeal. The district court in North Carolina similarly dismissed the dentists' motion to dismiss (following two very erudite opinions by FTC commissioners Kovacic and Rosch that rejected immunity), and the litigation is now pending before the Fourth Circuit following the dentists' appeal. Remarkably, in a tragically terse opinion, the Eleventh Circuit concurred with hospitals' claim for immunity. Reasoning that the state granted the county Hospital Authority the power to purchase hospitals, the court ruled, "In granting the power to acquire hospitals, the legislature must have anticipated that such acquisitions would produce anticompetitive effects."[55] The FTC has petitioned the Supreme Court to review the case.

These three cases offer the circuit courts and the Supreme Court the opportunity to clarify the state action immunity doctrine and limit the growingly popular maneuver among health care providers to get protection for anticompetitive conduct. Leaving aside the providers' weak doctrinal arguments, both the courts and antitrust enforcers should recognize the consequences of leaving unchallenged a legal opportunity for provider monopolists to avoid prosecution. The dangers of permitting monopolists to dominate certain markets are exacerbated when a monopolist has an additional opportunity to exploit a political process that bestows monopoly power. Both the likelihood of monopolization and the potential for political graft are greatly increased. In a highly regulated and highly subsidized industry in which political

machinery already serves private ambitions, the borders of a doctrine that protects politically connected monopolists need to be carefully patrolled.

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

One promising step could be to require hospitals and other provider entities to unbundle, at a purchaser's request, certain services so that the purchaser can negotiate prices. Providers routinely bundle services for unified payments, which can increase efficiency and reduce costs associated with providing closely intertwined services. However, when providers bundle monopolized and unmonopolized services, anticompetitive consequences can result: the monopolist can squeeze out rivals in the competitive market, creating for itself another monopoly, and by squelching rivals in the competitive market, the monopolist limits entrants' ability to challenge its hold on the monopolized market. The magnified consequences of health care monopolies should heighten concern over practices that can expand or enshrine provider monopolists.

The general antitrust rule on tying is that a firm with market power may not force customers to purchase unwanted goods or services.[56] If this principle is invoked to frustrate hospitals' practice of negotiating comprehensive prices for large bundles of services, purchasers could then bargain down the prices of services with good substitutes.[57] If a hospital still wishes to fully exploit its various monopolies, it would have to do so in discrete negotiations, making its highest prices visible. Health plans could then hope to realize significant savings by challenging such monopolies, either by inducing enrollees to seek care in alternative venues (effectively expanding the geographic market) or by encouraging other providers to enter the monopolized market. Often the mere threat of new entry is sufficient to modify a monopolist's demands, but entry is more credible if the monopolized service is discrete and associated with a distinct price that entrants can target.

To date, there have been only limited efforts to prevent hospitals from tying their services together in bargaining with private payers.[58] Although hospitals would argue that bundling generally makes for efficient negotiating and streamlined delivery of care, the added costs of bargaining service by service could be easily offset by the lower prices resulting from greater competition. Recent scholarship on tying and bundling confirms that permitting a hospital monopolist to tie unrelated services expands the monopoly's reach, profitability, and longevity and harms consumer welfare.[59] The extreme harm from health care monopolies makes these practices particularly appropriate for antitrust scrutiny.

A workable rule would permit antitrust law to empower a purchaser to demand separate prices for divisible services that are normally bundled.[60] Although one hopes that antitrust courts and a credible threat of treble damages would discourage a provider monopolist from retaliating against any purchaser that aggressively challenges its anticompetitive practices, the costs and delays from such complex antitrust actions suggest that public enforcement should supplement private suits. Either regulators could enable individual payers to demand unbundling to facilitate their efforts to get better prices or regulators could demand it themselves. This could trigger more competition and greater efficiency in both the tied submarkets where monopoly is not a problem and the tying markets where it is.

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 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 reduce frequent

and costly renegotiation of prices. However, their anticompetitive effects may sometimes outweigh their efficiencies. 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 not to charge lower prices to its competitors. Such a situation apparently arose in Massachusetts, where the commonwealth's largest insurer, a BlueCross plan, reportedly acceded to Partners HealthCare's demand for a very substantial price increase only after Partners agreed to "protect Blue Cross from [its] biggest fear: that Partners would allow other insurers to pay less."[61]

Antitrust law can offer relief against a provider monopolist that secures its high prices through an MFN clause with a powerful insurer. Because such clauses protect insurers against their competitors' getting better deals, many insurers are likely to give in too quickly to even extortionate monopolist price demands. But the availability of an antitrust remedy (which would probably be only a prospective cease-and-desist order rather than an award of treble damages for identifiable harms) might not be sufficient to deter a powerful provider from granting MFN status to a dominant insurer. Alternatively, regulatory authorities could prohibit dominant providers from conferring such status. Regulators presumably would be in as good a position as any party to distinguish between restrictive agreements that achieve transactional efficiencies and agreements that restrict insurers' freedom to cut price deals with competitors. Regulators might also be sensitive to how MFN clauses can reduce pressure on, and opportunities for, all insurers to seek new and innovative service arrangements.

A more potent antitrust attack on anticompetitive MFN clauses would aim at the dominant insurer demanding them, rather than at the cooperating provider. The DOJ has recently sued BlueCross BlueShield of Michigan, a dominant insurer, to enjoin it from using MFN clauses in its contracts with Michigan hospitals. It alleges that such MFN restrictions preclude provider price competition and have thus prevented other insurers from negotiating favorable hospital contracts.[62] Because the MFN clauses in the Michigan case are alleged—and seem likely—to have raised prices paid by BlueCross's competitors and by self-insured employers, they provide promising targets not just for public enforcement but also for private actions by injured purchasers, in which damages would be measured (and then trebled, in accordance with the Sherman Act) by any higher costs the restrictions forced them to incur. Indeed, in the wake of the government's suit in Michigan,[63] the threat of private lawsuits might quickly end large insurers' use of MFN agreements. In Massachusetts, for example, the BlueCross plan should now think long and hard before renewing (or enforcing) the MFN clause in its contract with Partners HealthCare.

ACOs could engineer and leverage greater monopoly power in an already-concentrated health care market.

Other contract provisions that threaten price competition are also in use in provider-insurer contracts in Massachusetts, according to the commonwealth's attorney general.[64] In particular, so-called "antisteering" 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.[65] Other contractual terms in use in Massachusetts (and quite possibly in other markets where BlueCross is dominant) guarantee a dominant provider that it will not be excluded from any provider network the health plan might offer its subscribers.

The contractual terms noted here all enshrine the cooperative supremacy of dominant providers and dominant insurers. The resulting competitive harm extends beyond the sustenance of high prices. These partnerships also foreclose opportunities for consumers to benefit, both directly as patients and indirectly as premium payers, from innovative insurance products that competing health plans might otherwise introduce. Antitrust rules can prohibit the use

of such anticompetitive contract terms to protect provider monopolies and curb insurer innovation, and insurance regulators might also bar such provisions wherever they threaten to preclude effective price competition. These actions remain available even in the continued presence of a provider monopoly.

Prospects for Meaningful Competition

Many commentators have suggested that the provider monopoly problem is severe enough to warrant considering the more radical alternative of regulating provider prices. Indeed, a growing number of health policy scholars have already concluded that "because 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."[66] Seeking price regulation, as opposed to market-oriented, solutions to the growing provider monopoly problem might become even more attractive after the PPACA, as the act puts in place a regulatory framework that meaningfully restricts how insurers can purchase health services. It seems that a policy apparatus akin to utility regulation would emerge naturally from the insurance exchanges and current provider monopolists, wherein dominant providers assume the role of a protected quasi-public utility and policymakers set prices and output.

Conceding to a utility model means giving up the potential benefits of competition. Even though the current system arguably is the worst of all possible worlds—unrestrained private spending and unabashed private profit motives secured with public regulations that discourage entry or structural change—many, especially economists, maintain faith in the entrepreneurial promise of market forces. Wholesale reconfiguration of the delivery system and attention to individualized needs, for example, are more likely to emerge from a decentralized system. Thus, even with a highly concentrated provider market, public policies and private initiatives can stimulate competition in health care and the resulting benefits of market forces. The likelihood that competition-oriented initiatives will succeed is a function both of the conviction underlying those policies and the flexibility that the PPACA's regulators furnish to market innovators.

Administrative Restraints and Interregional Competition. The PPACA's passage was largely motivated by Americans' deep frustration with (and, often, distrust of) insurance companies. To be sure, America's insurers have not done much to endear themselves to their subscribers, failing to convince many Americans that they possess the commitment and innovative zeal to create greater value in the health care delivery system they finance. In response, the PPACA limits what health plans can spend on administration, including imposing a "medical loss ratio" that requires insurers to expend a minimum percentage of their operating budget on health care services.[67]

Among the "administrative" costs this limits are investments in monitoring and improving the delivery of care. Such monitoring and organizational costs are frequently decried as costly intrusions on the doctor-patient relationship, but they have the potential to meaningfully streamline and even transform the delivery of care. Requiring minimum expenditures in medical services will only exacerbate the harms of moral hazard, including excessive consumption, overincentives to use expensive but cost-ineffective technologies, and restrictions on payers' ability to negotiate competitive prices. Anyone concerned with provider monopolies would be alarmed that medical loss ratios might further disarm payers in aggressive price negotiations with providers. But the larger cost in restricting administrative expenses is the possibility that it will stamp out innovations in the organization of health care delivery.

The most effective mechanism in battling local monopolies in health care might be the same mechanism used to combat costly local or domestic producers of other goods: expanding the locus of competition. Some self-insured employers have already begun to creatively exploit national competition, 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.[68]

Although most insurers are committed to preserving mutually beneficial relationships with local providers, some have also started searching for out-of-network providers to deliver care to their subscribers. United Healthcare, for example, has experimented with offering its insureds from across the United States the option to seek care from Mayo Clinic physicians and hospitals as in-network providers.[69] Some adventurous employers and insurers are even sending their subscribers abroad. BlueCross BlueShield of South Carolina has even created a subsidiary for medical tourism, Companion Global Healthcare, that maintains a network of international doctors and accredited institutions in thirteen countries, including Thailand, India, Costa Rica, Ireland, and Turkey.[70]

When purchasers of health care services start shopping nationally and internationally for providers, competitive forces awaken with the potential to reshape provider strategies. Many providers have aimed to capitalize on the expanding markets for health care travel, with several specialty hospitals in the United States now seeking to attract patients from insurers and other medical intermediaries.[71] In the same vein, providers outside the United States—for example, in the Cayman Islands and India—are marketing themselves to self-insured employers and insurers seeking high-quality services at competitive prices for their subscribers.[72]

Although traveling for health care might introduce a new set of costs, it is a highly effective way to infuse competition into locally monopolized markets. Moreover, the effects of such competition should not be underestimated. Broadening the geographic market ushers in new providers that can introduce new strategies, training, and orientations toward health care delivery. Exposure to diverse strategies and new organizational delivery mechanisms can only intensify competition that rewards cost-reducing innovations local monopolies are not inclined to pursue.[73]

In short, facilitating interregional competition could loosen the grip of some monopolists. Because certain health care services can be delivered only by local providers (although distance technologies continue to push the envelope), meaningfully reducing the costs of health care monopolies will continue to require the other initiatives I have described. The emergence of medical tourism offers enormous potential to bring down health care costs and improve quality. However, the PPACA's implementation—and, in particular, its calculation and employment of the medical loss ratio—might hamstring insurers and self-insured employers from investing in this innovative form of shopping for health care.

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"Essential Health Benefits" and Far-Sighted Health Care. Another of the PPACA's regulatory requirements—perhaps the most important and certainly, given its import, the most underscrutinized—is its requirement that by 2014, all health plans, both those offered in insurance exchanges and those offered externally, cover, at minimum, "essential health benefits."[74] Such benefits must be "equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary [following a survey of private plans]."[75]

Some have already observed that this requirement means that "consumers with this new statutory entitlement . . . will be locked into a system reflecting not their own preferences, values, and interests but those of the health care industry itself and its most elite customers. They will have little opportunity to purchase less costly coverage in order to put the available resources, either their own or society's, to what they might regard as better use."[76] Federal rules that define what insurers must offer as benefits actually impose as much, if not more, of a "mandate" on consumers than does the general "individual mandate" to purchase insurance. Constitutional challenges to the PPACA—alleging infringements to personal liberty—have

focused exclusively on the latter requirement to purchase minimum coverage,[77] but the final scope and scale of the essential health benefits provision is more likely to be the biggest constraint on consumer freedom. This requirement might also prevent meaningful reform to health care delivery that, in addition to providing value to consumers, could effectively challenge health care monopolists.

Perhaps the most burdensome feature of the essential health benefits requirement is its preoccupation with traditional medical services. Much has been written about the nation's unsustainable reliance on expensive traditional care, but a growing body of literature has additionally suggested that a menu of low-cost, nonmedical alternatives can produce results superior to traditional care. New Jersey's Medicaid program, featured recently in the *New Yorker*, has both improved outcomes and reduced costs for expensive patients by providing counselors and social workers to address life habits that exacerbate debilitating chronic illnesses.[78] The key has been transforming the delivery system from one that responds to consumers seeking medical services to one that aggressively targets patients with behavioral interventions. Similar efforts have proven effective in Massachusetts, where a variety of nonmedical interventions—a targeted intervention for hypertension self-management, tailored behavior change goals and skills training, peer support groups, informational resources through website and telephone support, and periodic telephone counseling calls—proved similarly successful in reducing obesity and hypertension in a high-risk, socioeconomically disadvantaged patient population.[79]

These results largely confirm earlier successes in Medicaid demonstration projects[80] and research examining health effects of Head Start programs,[81] which found links between behavioral interventions and far-sighted health behaviors. Although no magic formula or established regimen reliably induces useful behavioral changes, the potential health benefits from nonmedical interventions are undeniable. Health plans eager to experiment with low-cost and creative nonmedical interventions—especially those interested in preempting costly medical care—should be encouraged to do so.

Just as monopoly power in local markets should spur provider competition across regions, monopoly power in markets for traditional health care services should spur a search for viable nonmedical substitutes. To be sure, there is a reason Medicaid beneficiaries—who do not have the luxury of protesting unconventional benefits packages—have been the ones subject to experimentation with nonmedical interventions thus far; similarly, there is a reason that Medicaid administrators, rather than private payers, have been the ones forced to experiment. Indeed, private insureds would need a deep appreciation of both the unsustainability of current spending trajectories and the enormous savings (and comparable outcomes) available from nonmedical interventions before being comfortable with such a move. But because our trajectory is indeed dire, pursuit of a foundational reconceptualization of health care delivery is not so far-fetched. The implementation of PPACA's regulations—how medical loss ratios are calculated and what qualifies as essential health benefits, for example—will significantly determine whether federal policies encourage or impede this sort of experimentation.

Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving insured consumers exposed to monopolized health care markets. Because health insurance, especially as it is designed and administered in the United States, hugely expands a monopolist's pricing freedom, market power causes wealth-redistributing and misallocative effects substantially more serious than conventional monopoly power. Although this point has been almost completely absent from the antitrust and economics literature,[82] its importance plausibly dwarfs all other factors responsible for the extraordinarily high cost of US health care.[83]

Vigorous, rather than tentative or circumspect, enforcement of the antitrust laws can mitigate the harms from provider market power. Retrospectively scrutinizing earlier horizontal mergers of hospitals or

other providers could help correct decades of ineffectual enforcement, but if looking backward remains unlikely, renewed rigor moving forward is all the more essential. Parties proposing new mergers and alliances, whether traditional associations or new ACOs, must convincingly show that their reorganization either leads to only a minimal increase in market power or creates specific efficiencies. Other measures should target current monopolists to prevent the enshrinement or expansion of their market dominance. An antitrust or regulatory initiative to curb hospitals' bundling practices and 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 US-style health insurance.

The exorbitant prices for monopolized medical services should encourage health insurers to develop creative alternatives, both seeking effective (and less costly) substitutes and reorganizing what has become a fragmented, error-prone, and inefficient delivery system.

Another path to reducing the power of provider monopolies is to encourage creativity among third-party purchasers. Health plans that bypass, or foster new competitors for, local monopolists promote price and quality competition where it is currently lacking, thus undermining the potency of insurance plus monopolies. A pro-competition regulatory agenda should seek ways to facilitate such interregional competition, or at the very least scrutinize how medical loss ratio rules and other regulations might impede it. Additional hope lies in the possibility that health insurers and third-party purchasers will purchase (and that PPACA regulations will let them purchase) proven nonmedical interventions that improve health and reduce health care costs. The exorbitant prices for monopolized medical services should encourage health insurers to develop creative alternatives, both seeking effective (and less costly) substitutes and reorganizing what has become a fragmented, error-prone, and inefficient delivery system.

Unfortunately, health insurers have not shown much eagerness to either contest provider market power or pursue meaningful innovations providing care for their subscribers. As investigations in Michigan and Massachusetts reveal, insurers all too often become coconspirators with provider monopolists, agreeing to exclusive agreements that protect both themselves and monopolists but gouge consumers. Insurers' failure to act as aggressive purchasing agents for consumers is due partly to how the true cost of insurance remains hidden and partly to consumers' undue reluctance to accept anything less than the best. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their insurers. But US health plans appear inadequately motivated to reduce costs and overly hesitant to adopt innovative strategies with associated legal or political risks. Any hope for the future of US health care is tempered by doubts about the ability and willingness of US health insurers—as well as insurance regulators and elected officials who purchase insurance for public employees—to take the aggressive actions needed to procure appropriate, affordable care.

The PPACA, by expanding the reach of health insurance to many additional millions of Americans, has the potential to aggravate and extend the significant shortcomings of such insurance. Not only does the new law seem to have no effective answer to the problem of provider and supplier monopolies, but its broad extension of coverage is likely to further amplify the uniquely harmful effects of their market power. Moreover, its new regulatory requirements—imposing medical loss ratios and essential health benefits, for example—might constrain innovations among payers that might create interregional provider competition or reconfigure a deeply inefficient health care delivery system. Despite these new regulatory layers, antitrust policymakers and other regulators

still have the capacity to foster value-enhancing innovation—primarily by preventing the continued enshrinement of current monopolies. And although current tax policies and regulations have turned many insurers into agents for providers rather than for their subscribers, a potent opportunity remains for third-party payers to inject the health care sector with value-creating innovations that redesign both the offerings and the delivery of care.

Whatever the PPACA may achieve, its legacy and cost to the nation will depend largely on whether market actors, regulators, and antitrust enforcers can effectively address the provider monopoly problem and instill desperately needed competition among providers. 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. Competition-oriented policies, however, could yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for its increasingly limited resources.

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Notes

1. For an exception that proves the rule, see Avik Roy, "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," The Apothecary, August 22, 2011, www.forbes.com/sites/aroy/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about/ (accessed May 2, 2012)

2. The misallocation stems from incentives to produce and purchase too much, rather than too little, of services and products from providers with monopoly power. For a more detailed and documented exposition of how US-style health insurance inflates the various costs of monopoly in health care markets, see Clark C. Havighurst and Barak D. Richman, "Distributive Injustice(s) in American Health Care," *Law and Contemporary Problems* 69, no. 4 (Autumn 2006): 7, 13–31. See also Clark C. Havighurst and Barak D. Richman, "The Provider Monopoly Problem in Health Care," *Oregon Law Review* 89, no. 3 (2011): 847–84.

3. William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation, Research Synthesis Report 9, February 2006), www.rwjf.org/files/research/no9researchreport.pdf (accessed May 3, 2012); Claudia H. Williams, William B. Vogt, and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation, Policy Brief 9, February 2006), www.rwjf.org/files/research/no9policybrief.pdf (accessed May 3, 2012).

4. Ibid. For surveys of how hospital consolidations have increased hospital prices, see Gloria J. Bazzoli et al., "Hospital Reorganization and Restructuring Achieved through Merger," *Health Care Management Review* 27, no. 1 (2002): 7–20; Martin Gaynor, "Competition and Quality in Health Care Markets," *Foundations & Trends in Microeconomics* 2, no. 6 (2006): 441–508. For documentation of the extent of provider market concentration among hospitals and other providers, see also William B. Vogt, "Hospital Market Consolidation: Trends and Consequences," NIHCM Foundation *Expert Voices* (November 2009), http://nihcm.org/pdf/EV-Vogt_FINAL.pdf (accessed May 3, 2012).

5. Cory Capps and David Dranove, *Market Concentration of Hospitals* (Bates White Economic Consulting Analysis, June 2011), www.ahipcoverage.com/wp-content/uploads/2011/10/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf (accessed May 3, 2012).

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

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

8. Diana Farrell et al., *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More,* (McKinsey Global Institute, 2008); Gerard Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Heath Affairs* 22, no 3 (2003): 89–105.

9. See notes 3–4.

10. David A. Hyman et al., *Improving Health Care: A Dose of Competition* (US Federal Trade Commission and US Department of Justice, 2004), www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf (accessed May 3, 2012).

11. Section 1003 of the PPACA, which amends § 2794 the Public Health Service Act (42 USC 300gg - 91 et seq.), includes "rate review" provisions that require either state or federal officials to review notices of health insurance rate increases that exceed 10 percent. Theoretically, these constraints would prevent insurers from dramatically increasing rates that might be triggered by increases in provider monopoly power. Critics have countered that the provisions cause insurers to preemptively issue rate increases because they know future increases might be capped. In any event, constraining insurers' ability to increase premium rates is unlikely to constrain provider monopolists from seeking every last dollar from third-party and first-party payers.

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

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

14. Richard A. Posner, *Antitrust Law: An Economic Perspective*, 2nd ed. (University of Chicago Press, 2001), 13–18. To be sure, firms' general preference for reaping, rather than squandering, profits serves to ameliorate the full potential for wasteful spending. See William F. Baxter, "Posner's Antitrust Law: An Economic Perspective," *The Bell Journal of Economics* (1977): 609–19.

15. *United States v. Alcoa*, 148 F.2d 416, 430 (2d Cir. 1945).

16. See David Dranove, *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care* (Princeton, NJ: Princeton University Press, 2002), 122. ("I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.") See also Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform," *Health Affairs* 29, no 4 (2010): 699, 704. (Quotes 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.")

17. In 2009, the United States spent $7,960 per capita in total health care expenditures (purchasing power parity adjusted), nearly twice the OECD average, and 17.4 percent of its GDP, with no other OECD nation spending more than 12 percent. See Organisation for Economic Co-operation and Development, *OECD Health Data 2011*, www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html (accessed May 25, 2012).

18. American Hospital Association, *AHA Hospital Statistics* (Washington, DC: Author, 2012).

19. Hyman et al., *Improving Health Care*, ch. 4, 1–2 (note 10).

20. For discussions of these cases and of the general ambivalence toward competition in health care markets, see Barak D. Richman, "Antitrust and Nonprofit Hospital Mergers: A Return to Basics," *University of Pennsylvania Law Review* 156 (2007): 121–150; Martin Gaynor, "Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement," *Journal of Health Policy, Policy and Law* 31 (2006): 497–510; Thomas L. Greaney, "Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law," *American Journal of Law and Medicine* 23 (1997): 191–220.

21. See, for example, In the Matter of Evanston Nw. Healthcare Corp., 2007 WL 2286195, *53 (FTC 2007).

22. See note 3 above.

23. Hyman et al., *Improving Health Care*; Capps and Dranove, *Market Concentration of Hospitals*.

24. The district judge in *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (WD Mich. 1996), was especially unambiguous in championing nonprofit hospitals as benign monopolists, stating, "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" (1302). Likewise, the judge revealed a hostility to price competition between hospitals, remarking, "In the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars." The

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

25. *United States v. Brown University,* 5 F.3d 658 (1993).

26. Rev. Rul. 69-545, 1969-2 C.B. 117.

27. Rev. Rul. 56-185, 1956-1 C.B. 202.

28. Even while the ranks of the uninsured, both in aggregate and as a percentage of the population, grew steadily throughout the past three decades, uncompensated care as a fraction of total health expenditures remained constant. Uncompensated care is estimated to approach $56 billion in 2008, but as much as 75 percent was paid for by federal and state subsidies. Hospitals provided $35 billion in uncompensated care that same year, with over 80 percent paid by public subsidies. Uncompensated care provided by hospitals has similarly remained steady, at 6 percent of hospital costs, over the same period. See John Hadley, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27, no. 5 (September 2008): w399–415.

29. See generally Clark C. Havighurst and Barak D. Richman, eds., "Who Pays? Who Benefits? Distributional Issues in Health Care," *Law and Contemporary Problems* 69, no. 4 (2006).

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

31. Herbert Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice*, 3rd ed. (St. Paul, MN: Thomson/West, 2005), 50. ("[S]tatements [made during debates] may suggest that the primary intent of the Sherman Act's framer was not economic efficiency at all, but rather the distributive goal of preventing monopolists from transferring wealth away from consumers.")

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

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

34. For a chronicling of government challenges to mergers that lost in federal court, see Hyman et al., *Improving Health Care*. For an exploration of judicial resistance to enforcing the antitrust laws against hospitals, see Richman, "Antitrust and Nonprofit Hospital Mergers."

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

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

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

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

39. See America's Health Insurance Plans, *Accountable Care Organizations and Market Power Issues* (October 2010), www.ahip.org/Workarea/linkit.aspx?ItemID=9222 (accessed May 25, 2012); Berenson, Ginsburg, and Kemper, "Unchecked Provider Clout" (which notes ACOs' "potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power"); and Jeff Goldsmith, "Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms," *Health Affairs* 29, no. 7 (2010): 1299, 1304. ("Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen.").

40. Robert Pear, "Consumer Risks Feared as Health Law Spurs Mergers," *New York Times,* November 20, 2010.

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

42. The final rule requires that ACOs achieve the quality performance standard on 70 percent of the measures in each domain. Although this dilutes the requirements under the proposed rule, the rule asserts, "If an ACO fails to achieve the quality performance standard on at least 70 percent of the measures in each domain we will place the ACO on a corrective action plan and re-evaluate the following year. If the ACO continues to underperform in the following year, the agreement would be terminated. We believe requiring ACOs to achieve the quality performance standard on 70 percent of the measures in each of the 4 domains establishes a feasible standard, while signaling to providers that they need to devote significant focus to performance in each domain." See Department of Health and Human Services, *Medicare Program*. How the CMS

implements ACO evaluations will heavily determine the program's trajectory and success.

43. 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 largely discredited. Even a monopolist provider would most likely be charging private payers a profit-maximizing price already. See Havighurst and Richman, "The Provider Monopoly Problem," 22 (note 40); Vivian Wu, "Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997," *International Journal of Health Care Finance and Economics* 10, no. 1 (2010): 61–83; Austin Frakt, "How Much Do Hospitals Cost Shift? A Review of the Evidence," *The Milbank Quarterly* 89, no. 1 (2011): 90–130; Michael A. Morrisey, *Cost Shifting: Separating Evidence from Rhetoric* (Washington, DC: American Enterprise Institute, 1994).

44. *California Retail Liquor Dealers Assn. v. Midcal Alum.*, 445 U.S. 97 105 (1980). (The challenged restraint is immune from Sherman Act scrutiny if it is "clearly articulated and affirmatively expressed as state policy.")

45. *Parker v. Brown*, 317 U.S. 341 (1943).

46. *Southern Motor Carriers Rate Conf. v. United States,* 471 U.S. 48 (1985).

47. *Columbia v. Omni Outdoor Advertising*, 499 U.S. 365 (1991).

48. The state action doctrine has been criticized repeatedly for its overbreadth. See, for example, *Report of the State Action Task Force*, Office of Policy Planning, Federal Trade Commission (September 2003).

49. For a recent appraisal of growing state action immunity claims, including a disproportionate share made by health care providers, see Peter C. Carstensen, "Controlling Unjustified, Anticompetitive State and Local Regulation: Where Is Attorney General 'Waldo'?," *Antitrust Law Journal* (forthcoming).

50. This suit and related conduct are discussed in detail in the section of this paper on anticompetitive agreements between providers and insurers.

51. *United States v. Blue Cross Blue Shield of Michigan*, Civil Action No. 10-cv-14155-DPH-MKM, Defendant's Motion to Dismiss, 9.

52. Docket No. 9343, *In the Matter of the North Carolina Board of Dental Examiners*, FTC File No. 081-0133. The Dental Board is accused of sending letters to nondentist teeth-whitening providers that they were practicing dentistry illegally, ordering them to stop, and issuing threats to some who were considering opening teeth-whitening businesses. The Dental Board also allegedly sent letters to third parties—mall owners and property management companies—warning them that their tenants were engaging in illegal conduct.

53. *North Carolina State Board of Dental Examiners v. FTC*, No. 11-1679 (4th Cir. 2011), Br. of Appellant.

54. *FTC v. Phoebe Putney Health System*, No. 11-12906 (11th Cir. 2011).

55. Ibid.

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

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

58. 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.

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

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

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

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

63. As of writing, the DOJ's suit against BlueCross BlueShield of Michigan (BCBS) has survived BCBS's motion to dismiss in the district court and BCBS's assertion of state action immunity on interlocutory appeal before the Sixth Circuit. Depositions are now proceeding under the district court's supervision.

64. *Examination of Health Care Cost Trends*, 40–44.

65. The following section explores possibilities for insurers and employer-purchasers of health care stimulating provider competition, both within and across state lines. See the "Administrative Restraints and Interregional Competition" section.

66. Berenson, Ginsburg, and Kemper, "Unchecked Provider Clout," 699.

67. PPACA § 9016, 124 Stat. at 872 (providing for a minimum "medical loss ratio"). Moreover, although insurers may use administrative expenses to limit their provider networks and will therefore sometimes be in a position to bargain for lower prices, those health plans offered through exchanges are additionally required to "ensure a sufficient choice of providers," which might make it difficult to exclude a dominant provider of an important service. See § 1311(c)(1)(B), 124 Stat. at 174.

68. Harlan Spector, "Lowe's Will Bring Its Workers to Cleveland Clinic for Heart Surgery," Cleveland.com, February 17, 2010, www.cleveland.com/healthfit/index.ssf/2010/02/post_27.html (accessed May 4, 2012). ("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.")

69. Mayo Clinic, "Mayo Clinic and UnitedHealthcare Announce New Network Relationship," news release, October 7, 2010, www.mayoclinic.org/news2010-rst/5993.html (accessed May 4, 2012).

70. M. P. McQueen, "Paying Workers to Go Abroad for Health Care," *Wall Street Journal,* September 30, 2008. ("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.")

71. Jennifer Lubell, "New Tourist Attractions," Modern Healthcare, June 15, 2009.

72. Geeta Anand, "The Henry Ford of Heart Surgery," *Wall Street Journal,* November 25, 2009 (detailing plans to build a 2,000-bed general hospital in the Cayman Islands where "procedures, both elective and necessary, will be priced at least [50 percent] lower than what they cost in the U.S.").

73. Barak D. Richman et al., "Lessons from India in Organizational Innovation: A Tale of Two Heart Hospitals," *Health Affairs* 27, no. 5 (2008): 1260–70.

74. PPACA § 1302(b)(2)(A), 124 Stat. at 164. Plan benefits offered in insurance exchanges may then differ only with respect to cost-sharing requirements. For the time being, self-insured Employee Retirement Income Security Act plans, and a shrinking number of "grandfathered" fully insured plans outside the exchange markets, will escape the essential benefits requirement.

75. Ibid. The proposed rule allows for some minimal state-by-state flexibility in determining the Essential Health Benefits requirement, allowing states to select certain existing insurance plans as their benchmark for the essential health benefits package. Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *Essential Health Benefits Bulletin* (December 16, 2011).

76. Clark C. Havighurst and Barak D. Richman, "Who Pays? Who Benefits? Unfairness in American Health Care," *Notre Dame Journal of Law, Ethics, and Public Policy* 25 (2011): 493–526.

77. See *Florida v. Dept. of Health & Human Services*, No. 11-400 (*certiorari granted*, November 14, 2011). For my own take on constitutional challenges to PPACA, see Barak D. Richman, "On the Constitutionality of Health Care Reform," *North Carolina Medical Journal* 71, no. 3 (2010): 232–38.

78. Atul Gawande, "The Hot Spotters," *New Yorker*, January 24, 2011.

79. Gary G. Bennett et al., "Obesity Treatment for Socioeconomically Disadvantaged Patients in Primary Care Practice," *Archives of Internal Medicine* 172, no. 7 (2012): 565–74.

80. See, for example, Margo L. Rosenbach et al., "Access for Low-Income Children: Is Health Insurance Enough?" *Pediatrics* 103, no. 6 (1999): 1167–74 (finding that a school-based health insurance program that replaced traditional fee-for-service insurance and offered outreach through the school lunch program and a private managed care contractor increased consumption of preventative care, decreased hospital utilization, and improved health outcomes).

81. Janet Currie and Duncan Thomas, "Does Head Start Make a Difference?" *American Economic Review* 85, no. 3 (1995): 341–64 (finding improved immunization rates among Head Start enrollees); Kate Irish, Rachel Schumacher, and Joan Lombardi, *Head Start Comprehensive Services: A Key Support for Early Learning for Poor Children* (Center for Law and Social Policy, January 2004) (finding higher rates of screening for medical conditions, immunizations, and dental care for Head Start enrollees).

82. Scholars have previously observed that prices for health services are much higher in the United States compared to other nations in the Organisation for Economic Co-operation and Development (without observable differences in quality). See, for example, Gerard Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Heath Affairs* 22, no 3 (2003): 89–105. Many have observed that provider market power is a factor in inflating those prices. See sources in notes 3-4 above. But few have observed the synergistic effects of monopoly and health insurance. For example, 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." The authors seem not to recognize that health insurance *itself* raises monopolists' prices or that the private "buy side" is especially (for reasons given notes 45–51 above and accompanying text), although not inevitably, helpless in fighting cost battles in the US system.

83. Excess health care spending in the United States was recently estimated to be $650 billion per year, equal to nearly 5 percent of gross domestic product. See Eric Jensen and Lenny Mendonca, *Why America Spends More on Health Care* (National Institute for Health Care Management, 2009), www.nihcm.org/component/content/article/409 (accessed May 4, 2012).