Antitrust law has been characterized as godfather to competition in health care, as landmark cases removed professional restraints of trade and challenged anticompetitive joint ventures and networks that had inhibited market approaches. More recently, antitrust may seem more like an absentee father, as unchecked consolidation over the past fifteen years resulted in markets with dominant providers whose high prices became a major driver of health cost inflation. With health care reform encouraging much-needed integration, policy makers and commercial payers have begun to question whether the law provided tools adequate to blunt the adverse effects of extant market power and whether judicial and enforcement resources would be able to prevent a recurrence of anticompetitive consolidations.

It is curious that antitrust law and competition policy remained in the shadows during the health reform debate. Only after its enactment did policy makers and commenters take notice of the fact that the Affordable Care Act’s strong reliance on competition (Greaney 2011) might be undermined by existing market structures and the incentives the law provides to consolidate further. In the foregoing article in this special issue, Robert F. Leibenluft (2015), one of the nation’s leading antitrust practitioners and a former Federal Trade Commission official, identifies many of the important challenges facing antitrust enforcers and tribunals going forward: for example, the need to take on both hard cases, including hospital-physician consolidations that foreclose competition or raise rivals’ costs, and innovative challenges reflective of rapidly changing industry
dynamics, such as cross-market mergers. He also points to important shortcomings in past approaches, such as the failure of enforcers to address the double-edged sword of network exclusivity, and points out deficits in economic learning about important topics such as the relative efficiencies of contractual arrangements and acquisitions. On several matters, however, I take issue with Leibenluft’s proposed agenda. Perhaps most concerning is his suggestion that enforcement might be relaxed (or redirected) whenever defendants might advance plausible arguments that consolidation—or perhaps even cartelization—might improve the prospect of “payment and delivery innovation” (Leibenluft 2015: 859) in care financed by both commercial and government payers. Given the wealth of research demonstrating the links between provider consolidation, leverage, and supra-competitive pricing (Vogt and Town [2006] 2012; Berenson, Ginsburg, and Kemper 2010), this is no time to tap the brakes on curbing concentrative mergers and joint ventures. Below I outline some thoughts about developing competition policy—not confined to antitrust enforcement—that will address the problems associated with provider consolidation.

The Past

Leibenluft’s article (2015) offers an accurate account of the history of antitrust challenges to hospital mergers and anticompetitive conduct, emphasizing the complexity of issues involved in these inquiries and the demanding standard that antitrust case law sets. Somewhat overlooked, however, is the role that judicial mistakes have played in permitting extensive consolidations to occur. An extensive economic literature and retrospective analyses have demonstrated that courts were too easily persuaded to find overbroad geographic markets—which spurred others to undertake concentrative acquisitions and likely caused government prosecutors to forgo challenging hospital mergers for almost seven years (Capps et al. 2001; Danger and Frech 2001; Langenfeld and Li 2001). The lessons from this period of judicial error and enforcement forbearance may have considerable relevance today: Are we witnessing another wave of consolidations that, left unchallenged or subject to laissez-faire judicial predilections, will have long-term repercussions in health care markets?

1. Weighing demonstrated efficiencies in the relevant market under examination has always been part of the antitrust framework for evaluating joint ventures and mergers. Therefore, I take Leibenluft both to advocate recognizing a broader conception of efficiencies (health system innovation-enhancing tendencies) and to suggest measuring their impacts beyond the private market.
Are government antitrust agencies and the courts up to the task of policing consolidation, or is a regulatory response required? And most problematically, what is to be done about extant market power?

The Present

Leibenluft’s assessment of today’s antitrust environment begins with a fundamental issue: Are enforcers asking the right question? Inefficiency in delivery systems, he asserts, “is undoubtedly a greater and more fundamental issue to address” than focusing on contracted rates to commercial payers (Leibenluft 2015: 859). Enforcers’ focus should turn to “the impact of a collaboration or consolidation on the likelihood of payment and delivery innovation, the significant efficiencies that might come from such efforts, and, of course, whether the benefits of such efficiencies are likely to be passed on to consumers” (Leibenluft 2015: 859). In proposing this adjustment, however, Leibenluft acknowledges that a central concern is whether a network or accountable care organization (ACO) joint venture will make it more difficult for other entities to form rival collaborations. If so, it would be incumbent on the proponents “to establish what will ensure that, in the absence of competition, they will continue to strive for ways to improve quality and lower costs and pass along savings where care is based on negotiated rates” (Leibenluft 2015: 860). This latter qualification, I would submit, illustrates the central deficiency of the author’s proposal. By what mechanism, short of committing the merged entity to regulatory oversight, might dominant providers supply “assurances” that it will not exercise market power by raising prices or engaging in expense preference behaviors that have long characterized the health care industry? Moreover, against what baseline might the network or ACO be judged?

In this connection, Leibenluft also endorses the use of so-called conduct decrees—settlements of antitrust challenges to anticompetitive mergers and joint ventures that allow transactions to proceed subject to judicially supervised controls—typically caps on rate increases, limitations on future affiliations, and limitations on bundled bidding for payer contracts. These decrees, adopted by a few state attorneys general, have been the subject of extensive criticism. In a recent decision the Superior Court of Massachusetts rejected a proposed settlement of the attorney general’s antitrust challenge to an acquisition of two hospitals by Partners HealthCare System, the dominant hospital system in the region (Commonwealth of Massachusetts v. Partners HealthCare System, Inc. & Others, No. SUCV2014–02033–BLS2, 20015WL50095). Responding to a variety of objections
The Future

Looking ahead, it is important to bear in mind Leibenluft’s (2015: 850) caution that “antitrust laws give dominant firms a substantial amount of leeway . . . and . . . great discretion regarding the prices they charge and the entities with which they wish to deal.” As I have argued elsewhere, because extant provider monopolies threaten to undermine the competitive framework of health reform, health policy needs to focus on targeted regulatory interventions to mitigate the effects of market power in many local areas (Greaney 2013b; Catalyst for Payment Reform 2013). Leibenluft is correct in urging an approach to competition policy that recognizes the interaction between commercial insurance markets and government-sponsored programs. For example, antitrust enforcement regarding ACOs might benefit from closer coordination with the Centers for Medicare and Medicaid Services (CMS). Although the Obama administration backed away (unwisely in my view [Greaney 2013a]) from requiring preclearance from the antitrust agencies for ACOs applying to participate in the Medicare Shared Savings Program, CMS’s final rule implementing the program pledged cooperation among the agencies to facilitate monitoring of competitive issues. Nevertheless, more robust interagency cooperation to deal with the provider monopoly problem may be in order (CMS 2011). As outlined in Robert Berenson’s (2015) article in this special issue, in supervising ACO formation and conduct, CMS might adopt measures that discourage structures that monopolize service markets or, when in calculating bonuses and penalties, take into account an ACO’s exercise of market power in commercial markets.

With the Medicare ACO experiment proceeding apace and showing modest if unspectacular success (McWilliams et al. 2014), policy analysts
are carefully studying ways to improve the Medicare shared savings model (McClellan et al. 2014) and to coordinate Medicare payment policies involving ACOs, Medicare Advantage plans, and fee-for-service payment (MedPAC 2014). Owing to the siloed regulatory regimes governing public and private payment systems, however, little attention is being paid to the spillover effects of Medicare payment on private markets and vice versa. Indeed, the interaction of the two systems is generally overlooked. Although administered pricing under Medicare does not differentiate among providers based on their market leverage, provider market competition has a significant effect on hospital Medicare margins. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC 2009: xiv) has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that “when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise.” These factors, MedPAC (2009) observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets (Stensland, Gaumer, and Miller 2010). And low margins attributable to expense preference behavior by dominant hospitals may translate into higher Medicare costs. Moreover, as CMS noted in promulgating its final rule on ACOs, monopolists unable to raise prices because of regulation often reduce the quality or amount of inputs for their services. Hence inadequate competition in the private sector may lead to diminution in quality of care and access for Medicare beneficiaries (CMS 2011). Further, as CMS also acknowledged, competition in each market among ACOs (or perhaps between ACOs and Medicare Advantage plans) is needed to spur continuing innovation and cost-control efforts. These findings make a persuasive case for interagency coordination that would enable CMS to use its leverage to counter extant monopoly power as discussed above. Further, CMS’s close coordination with antitrust enforcement agencies, including gathering and sharing of information about the performance of ACOs in private markets, could enable the enforcers to evaluate and challenge the anticompetitive spillover effects of provider consolidation (Berenson 2015).

**Conclusion**

For health reform to succeed, much depends on provider integration. Consequently, in implementing new payment policies, pilots, and the ACO
program, CMS has sought to encourage both horizontal and vertical arrangements that serve to coordinate care and reshape delivery systems. At the same time, because excessive consolidation may undermine the cost-control and quality improvement goals of health reform, more—not less—attention from antitrust agencies and regulators is needed.

Thomas L. Greaney is Chester A. Myers Professor of Law and codirector of the Center for Health Law Studies at Saint Louis University School of Law. His research focuses on the application of antitrust law to the health care sector, health care financing, and health care law and policy. He is coauthor of a casebook, *Health Law: Cases, Materials and Problems* (7th ed., 2013), and a treatise, *Health Law* (3rd ed., 2015). He has testified on these issues before the Judiciary Committee of the US House of Representatives and the Federal Trade Commission. Before joining the Saint Louis University faculty, he served as an assistant chief in the Department of Justice Antitrust Division, supervising health care antitrust litigation. He has also been a Fulbright Fellow studying European Community competition law in Brussels, Belgium.

**References**


