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Invigorating Competition in Health Care Markets: Is Rate Regulation Needed?

BY TIM GREANEY *June 1, 2021*

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It now appears that market concentration may be the leading cause of America's health care cost crisis. If the United States is going to continue to rely on market competition to deliver a satisfactory blend of cost and quality, health care policy must address two critical questions: How did we get to this point, and what can be done?

As has now become widely recognized, the American health care system has a serious market power problem. Markets for local hospital and specialty physician care, health insurance, and intermediary services such as pharmacy benefit management and digital health care technology and consulting are all highly concentrated. In addition, vertical combinations, especially hospital acquisitions of physician practices, have increased exponentially. A sizeable economic literature shows that the resulting provider concentration has greatly elevated reimbursement costs for payers, which in turn has translated into higher premiums for consumers and employers—all with little, if any, enhancement in the quality of care provided.

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How Did We Get Here? Legal and Policy Failures

Inconsistent Merger Law Enforcement: As a general matter, the Clayton Act's goal of "arresting mergers at a time when the trend to lessening competition is in its incipiency" has been thwarted in health care by uneven enforcement and erroneous court decisions.

Antitrust merger enforcement in health care has been something of a bumpy ride. After years of mixed results in early challenges to horizontal hospital mergers, federal antitrust agencies and state attorneys general lost seven consecutive cases in federal courts, most based on dubious geographic market holdings by the courts. A period of quietude followed, as no mergers were challenged for approximately seven years and hospital market concentration increased significantly. However, a series of retrospective analyses undertaken by the FTC in the late 1990s demonstrating that many of the mergers approved by the courts did indeed result in higher prices reinvigorated attention to health care mergers. The FTC went on a winning streak, successfully challenging in federal court ten horizontal hospital mergers and one physician merger and the US Department of Justice stopped two major insurance plan combinations. But a recent loss by the FTC in its attempt to stop a hospital merger in Philadelphia illustrates the continuing complexity and uncertainty the government faces in meeting the antitrust law standard for proving relevant geographic markets, especially in urban and exurban markets.

Gaps in Antitrust Oversight of Market Dominance: Further, antitrust enforcement has neglected entirely some important areas of concern. No cases have been brought challenging the wave of vertical mergers as hospitals have engaged in a modern-day gold rush to beat their rivals in acquiring physician practices. Economic studies have confirmed that many of these acquisitions have enhanced the bargaining leverage of vertically integrated hospitals resulting in higher costs for payers and consumers. In addition, an emerging problem, which I term "system power," has drawn no attention from federal enforcers. By this, I mean the capacity of large, multi-hospital systems to extract surpracompetitive reimbursement for all their facilities by insisting on "all or nothing" contracts. By one estimate, the nation's 637 health systems are comprised of some 72 percent of the nation's hospitals and 50 percent of its physicians. Again, several empirical studies have demonstrated that so-called "cross market" mergers often enable systems with "must have" hospitals to extract high prices for all their facilities.

The Limited Benefits from Market-Improving Regulation and Antitrust Litigation

There are a number of regulatory initiatives that would improve the competitiveness of health care markets. For example, Medicare and commercial "site of service" payment policies reimburse hospitals that acquire physician practices at higher rates than paid to the same physicians when they practiced independently. This disparity in reimbursement has spurred a maelstrom of hospital acquisitions of physician practices, which have been shown to increase costs.

At the same time, other reforms often touted by those who assume health markets conform to neoclassical models have proved to be of limited efficacy. For example, while regulations increasing price transparency and encouraging reference pricing by payers may incentivize price competition to some extent, the net impact of those steps has been modest because most health care services are not "shoppable" and most patients do not avail themselves of access to price data prior to obtaining services. Likewise, mechanisms designed to increase insured consumers' sensitivity to price by rewarding consumers who choose less costly providers, such as high deductible plans and tiered benefit designs, are subject to inherent information deficits and behavioral biases that cabin their efficacy.

While there is no question that myriad market-improving policies can somewhat enhance the competitiveness of the health care system, the hard truth is that the horse has left the barn. Concentrated provider markets are now the norm, and the resulting bargaining leverage generates high prices.

Unfortunately, antitrust doctrine offers few remedies to deal with *extant* market power. Indeed, case law has sharply curbed the application of antitrust law to exclusionary conduct and unilateral acts by dominant firms. As an example, in his last published opinion, Judge Richard Posner excused the exclusive contracting by a dominant "must-have" hospital with payors on the theory that bi-annual "competition for the contract" would assure an adequate competitive outcome despite evidence of the price-elevating effects of the practice.

It is fair to assume that an increasingly conservative federal judiciary will continue to deploy the myriad presumptions and rules of thumb developed in antitrust precedent over the years that impair meaningful antitrust supervision of the conduct of dominant health care providers. Finally, a practical impediment undermines reliance on antitrust enforcement to curb the growth or exercise of market power. The extraordinary costs in resources and time render it impractical for state and federal antitrust authorities to effectively monitor and challenge anticompetitive conduct in the nation's thousands of local health service markets.

Targeted Rate Regulation: A Necessary Antidote to Provider Market Power?

Several approaches to dealing with America's provider market power problem have been advanced. One concept, which I call "disarmament," would outlaw some of the tools commonly used by dominant hospitals to limit competition. These tools are contractual provisions that "must have" hospitals often insist upon in their negotiations with payers, such as "anti-tiering/anti-steering" clauses that prohibit insurers from providing incentives for patients to use choose less costly facilities; "most favored nations" provisions which prohibit payers from striking more favorable terms with rival hospitals; and "all or nothing" requirements pursuant to which large systems demand high levels of reimbursements for all their facilities regardless of quality or competitive conditions in those markets.

In theory, some of this conduct might be challenged in court. For example, in a case brought by the Attorney General of California and private plaintiffs under state antitrust law, Sutter Healthcare, a large Northern California system, agreed to abandon using some of these practices and paid a significant damage award. As noted above however, such litigation is costly and time consuming, and is beyond the capacity of most state attorneys general.

Another disarmament approach is to simply outlaw use of the tools described above in provider/payer contract negotiations. A study by the University of California Hastings College of Law and the Petris Center at the University of California Berkeley examining state legislation designed to prohibit anticompetitive contracting practices demonstrated that only a handful of states have adopted such laws, although an increasing number of state legislatures have such bills proposing such restrictions under consideration. While similar federal legislation targeting such practices has been proposed, it seems doubtful that a deadlocked Congress will be eager to take on the subject, especially since states have long exercised control over health insurance contracting. Finally, disarmament does not diminish the inherent bargaining leverage of dominant providers. High prices are likely to persist, especially in rural markets, which are unlikely to support multiple hospitals or rivalrous specialty physician practices.

The most straightforward, albeit probably most controversial, initiative would be to adopt regulations capping the prices charged by dominant providers. As a matter of economic theory, durable monopolies—those not subject to likely entry by rivals or rapid innovation—require government regulation in order to maximize consumer welfare.

It therefore should come as no surprise that a number of leading healthcare economists have endorsed the concept. A noteworthy paper by Michael E. Chernew, Leemore Dafny, and Maximilian Pany offers a comprehensive roadmap to the regulatory apparatus needed for setting ceilings on the prices that can be charged by providers. Noting that competition-enhancing measures "are greatly limited … in their ability to contain the effects of existing market power," the authors endorse price caps as a means of "allowing market forces…to work when they can" but also inhibiting monopoly pricing by dominant providers. Rhode Island, an early adopter of a provider price control strategy, has enacted regulations prohibiting insurers from entering into contracts with providers that exceed a specified inflation index. One study attributes the reduction in health care spending growth in the state in part to the shift in bargaining dynamics caused by these regulations.

If history is a guide, if federal and state legislatures address health care reform at all, they are likely to focus on low-hanging fruit such as improving price transparency or eliminating obvious regulatory impediments to competition, like state Certificate of Need laws. The hard but essential work of dealing with provider market power may well prove too ambitious and politically fraught, especially for lawmakers deeply divided on virtually everything. Perhaps the most that can be hoped for is that a few states may follow Rhode Island's lead and take a stab at rate controls, if for no other reason than nothing else seems to work.