Antitrust Policy in Health Care: Searching for a Strategy That Works

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Outline of Presentation

• Brief outline of antitrust tools
• Discuss recent developments in “horizontal” mergers among hospitals, physicians, and health plans
• Summarize antitrust policy in “vertical” mergers
• Is antitrust a useful strategy for preserving competition in health care markets?
• Suggestions for improving antitrust enforcement
Antitrust Laws

- Sherman Act (1890): Section 2 prohibits monopolization and attempts to monopolize
  - Intended to prevent monopoly power in a single firm
  - Does not prohibit monopoly gained passively or by merit, only by acts that involve misconduct or coercion
- Clayton Act (1914): Section 7 prohibits mergers and acquisitions that may substantially lessen competition or create a monopoly
- Enforced by the U.S. Department of Justice and the Federal Trade Commission
- State antitrust laws are patterned after Sherman and Clayton Acts
Hart-Scott-Rodino Act

• 1976 amendments to the federal antitrust laws
• Both parties must notify FTC/DOJ in advance of certain mergers and cannot close the transaction before one of the agencies has evaluated its likely effect on competition
• Triggered by size of merger – one party has sales of $126.3 million in 2008
• One of the “most important and far-reaching changes in antitrust enforcement since the passage of the Clayton Act” – William J. Baer, Director, FTC Bureau of Competition, 1996
Business Review Letters

• Parties to a proposed business practice may request prior review by the DOJ
• DOJ states whether it would challenge the proposed practice
• Has been used in physician merger cases
• Can be applied to business practices that do not involve mergers
  • Washington State Medical Association wanted to conduct a survey of physician fees and publish the results
  • DOJ gave this request a pass
Hospital Mergers & Market Concentration

Mean Herfindahl Hirschman Index

Number of Hospital M&As

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Hospital Mergers and Price

Structure-Performance Studies
• Estimate relation between market structure measure such as HHI and price and simulate effect of hypothetical mergers
• Literature points to a small (~5%) price increase

‘Structural’ Merger Models
• Estimate demand for hospital services and simulate effect of hypothetical mergers
• Hospitals in systems (multi-hospital firms that result from consolidation) have prices 15% higher than independent hospitals

Event Studies
• Use data from before and after actual mergers to assess the effect of the merger on price
• Some event studies indicate large merger effects: hospitals located within 7 miles of a merging rival raise prices by 40%

W.B. Vogt and R. Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? RWJ Synthesis Project, Report No. 9, 2006
Hospital Concentration and Quality

- A literature review identified 10 studies that examined the effect of hospital concentration on quality of care
  - Evidence is mixed
  - The best studies find the increases in hospital concentration are responsible for increases in AMI mortality
  - The effect is found only in areas only with higher HMO penetration, where more hospital competition leads to better quality

W.B. Vogt and R. Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* RWJ Synthesis Project, Report No. 9, 2006
Hospital Mergers and Insurance Coverage

# Hospital Merger Cases 1995-99

<table>
<thead>
<tr>
<th>Setting</th>
<th>Year</th>
<th>Reason for Court’s Rejection of Govt. Case</th>
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<tbody>
<tr>
<td>Joplin, Mo</td>
<td>1995</td>
<td>Large geographic market</td>
</tr>
<tr>
<td>Dubuque, IA</td>
<td>1995</td>
<td>Large geographic market</td>
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<tr>
<td>Grand Rapids, MI</td>
<td>1996</td>
<td>Not-for-profit hospitals</td>
</tr>
<tr>
<td>Long Island, NY</td>
<td>1997</td>
<td>Broad product market</td>
</tr>
<tr>
<td>Poplar Bluff, MO</td>
<td>1999</td>
<td>Large geographic market</td>
</tr>
</tbody>
</table>

D. Haas-Wilson, Managed Care and Monopoly Power: The Antitrust Challenge, 2003, p. 91
“Community Payment”
Justification

• Other hospital mergers have been allowed to proceed with community payments, e.g. the merging hospitals promise to pay for charity care

• Hospitals do this anyway, so the marginal payment is difficult to monitor

• If the merger raises prices, it creates a loss of welfare, and using some of the merger profit to fund charity care does not reduce that loss
Evanston Hospital Merger

• 2000: Evanston Northwestern Healthcare (ENH) and Highland Park Hospital merge
• 2004: FTC files complaint alleging that the merger allowed ENH to raise prices above competitive levels
• 2005: Administrative law judge orders ENH to divest Highland Park Hospital
• 2007: FTC affirms ALJ’s ruling but does not insist on divestiture; proposes that ENH set up separate teams to negotiate contracts with insurers
• 2007: Eight economists file Amicus Curiae brief arguing that separate bargaining would be a sham
• 2008: FTC issues final order approving separate-team proposal (FTC, Final Order, Docket No. 9315, April 24, 2008)
Inova Merger

• 2006: Inova Health System Foundation proposes to acquire Price William Health System
  – Inova is the largest hospital system in Northern VA
  – PWHS operates a 180-bed hospital in the area
  – Inova would have had 73% of the licensed beds in Northern VA
• 2008: FTC announces it will undertake full administrative hearing on the matter (*FTC v. Inova*, May 9, 2008)
• 2008: Inova calls off merger
Implications of ENH and Inova

- In both ENH and Inova, the FTC claimed that the mergers would violate Section 7 of the Clayton Act that forbids mergers that may substantially lessen competition.
- Both cases mark FTC’s willingness to use its administrative processes rather than seeking relief through the federal courts.
- While the ENH remedy is disappointing, these recent cases set a precedent that may undo the effect of previous government failures to prevail in hospital merger cases.
Physician Mergers

• No data on physician market structure levels and changes
• But plenty of anecdotal evidence of market power, e.g. doctors threatening to terminate managed care contracts if payment demands are not met
• FTC/DOJ haven’t challenged any physician merger
• But business review letters set a precedent for legal challenges:
  • DOJ declined to approve creation of a network including 50-75% of the pediatricians in a market
  • Similarly, it did not approve an exclusive contracting entity for 30% of the anesthesiologists in a market
• DOJ will define the geographic market locally and the product market narrowly
Health Plan Mergers

• DOJ has prevailed in 3 health plan merger cases:
  • Aetna-Prudential (1999)
  • UnitedHealth Group-Pacificare (2005)
  • UnitedHealth Group-Sierra Health Services (2008)

• There are clear ground rules for defining the geographic market for health plans:
  • Managed care plans require local provider networks
  • Plans located outside the local area (generally an MSA) are not a competitive constraint on a merger

• Less clarity how to define the product market
Vertical Mergers

• “Upstream “ and “downstream” firms merge, e.g. health insurer and hospital or more commonly, hospital and physicians

• Economics and law of vertical mergers are not settled
  • Vertical mergers may increase efficiency – the idea behind Accountable Care Organization (ACO) proposals
  • Vertical mergers may increase market power and lead to anti-competitive practices
  • FTC/DOJ view vertical mergers with “rule of reason”
Antitrust Cons

- Antitrust cases are long, complex, and costly
- The outcome is subject to the whim of a court, e.g. non-profit hospital mergers are ok
- FTC/DOJ have a poor track record in opposing hospital mergers and have not challenged a single physician merger
- Health care mergers are too numerous for antitrust to be a meaningful strategy
  - Health care is a local industry with many participants
  - Physicians and hospitals in small markets have high market shares, so almost every merger in those markets is potentially anti-competitive
- The remedy can be inadequate, e.g. ENH case
Antitrust Pros

• The only alternative to antitrust for controlling health care costs is government price controls and monopsony buying power

• The government prevailed in ENH and the threat of legal action stopped the Inova merger

• Although no peer-reviewed study is available, I think successful merger challenges create a climate in which anti-competitive mergers are less likely to be proposed

• Business reviews of proposed physician mergers have set a precedent for legal challenges

• Ground rules have been established for health plan mergers
Suggestions (1)

• Hart-Scott-Rodino triggers should be lower for health care mergers
  – Current triggers are too high for many physician mergers
  – Antitrust challenges occur “after the fact,” when it is harder to dissolve the merger

• Federal and state agencies should coordinate their enforcement actions
  – States should be more active in investigating “local” mergers, e.g. among physician groups
  – State attorneys general should be allowed to conduct administrative reviews
  – Feds should not give merger ok if state is investigating

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Suggestions (2)

• FTC/DOJ should challenge physician mergers
  – Pick a clear-cut case such as a merger of two large single-specialty medical groups in a mid-size city and go after it
  – Set a precedent that future physician mergers will be challenged

• Agencies should be prepared to insist on divestiture as a remedy

• Do not accept the “community payment” justification for mergers