Antitrust Enforcement in Healthcare Markets
Physician practices and hospitals

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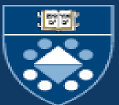

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Refresher on antitrust basics

Will run through a few graphs to fix conceptual framework

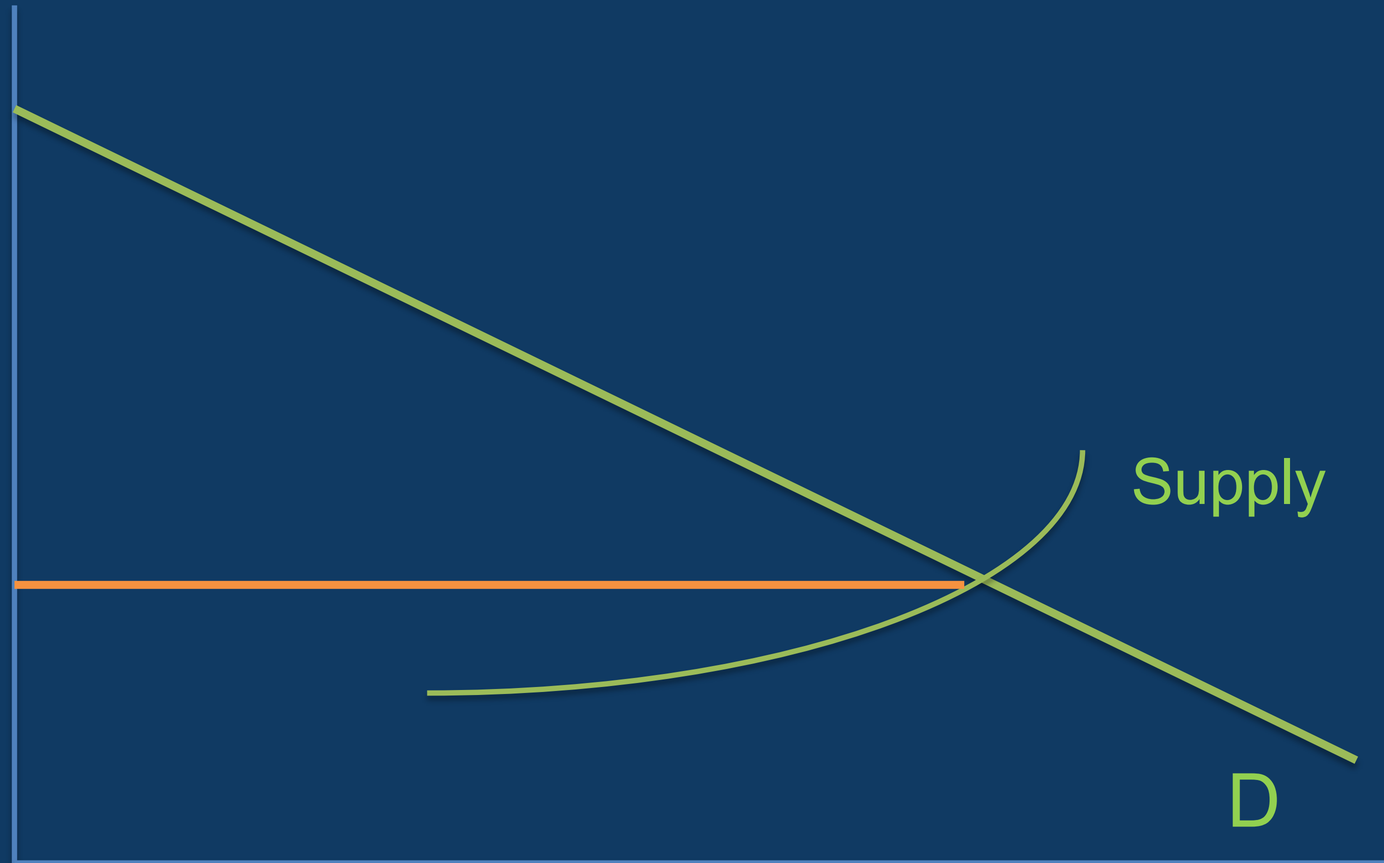
Demand Curve

Price

D

Quantity

Competitive
price

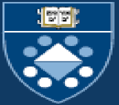


Consumer Surplus

supply

Competitive price

D



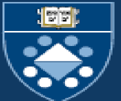
The monopoly price is higher than the competitive price

Monopoly price

Competitive price

Supply = MC

MR

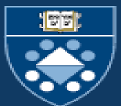


Consumer surplus shrinks

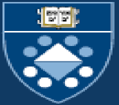
Monopoly price

Supply

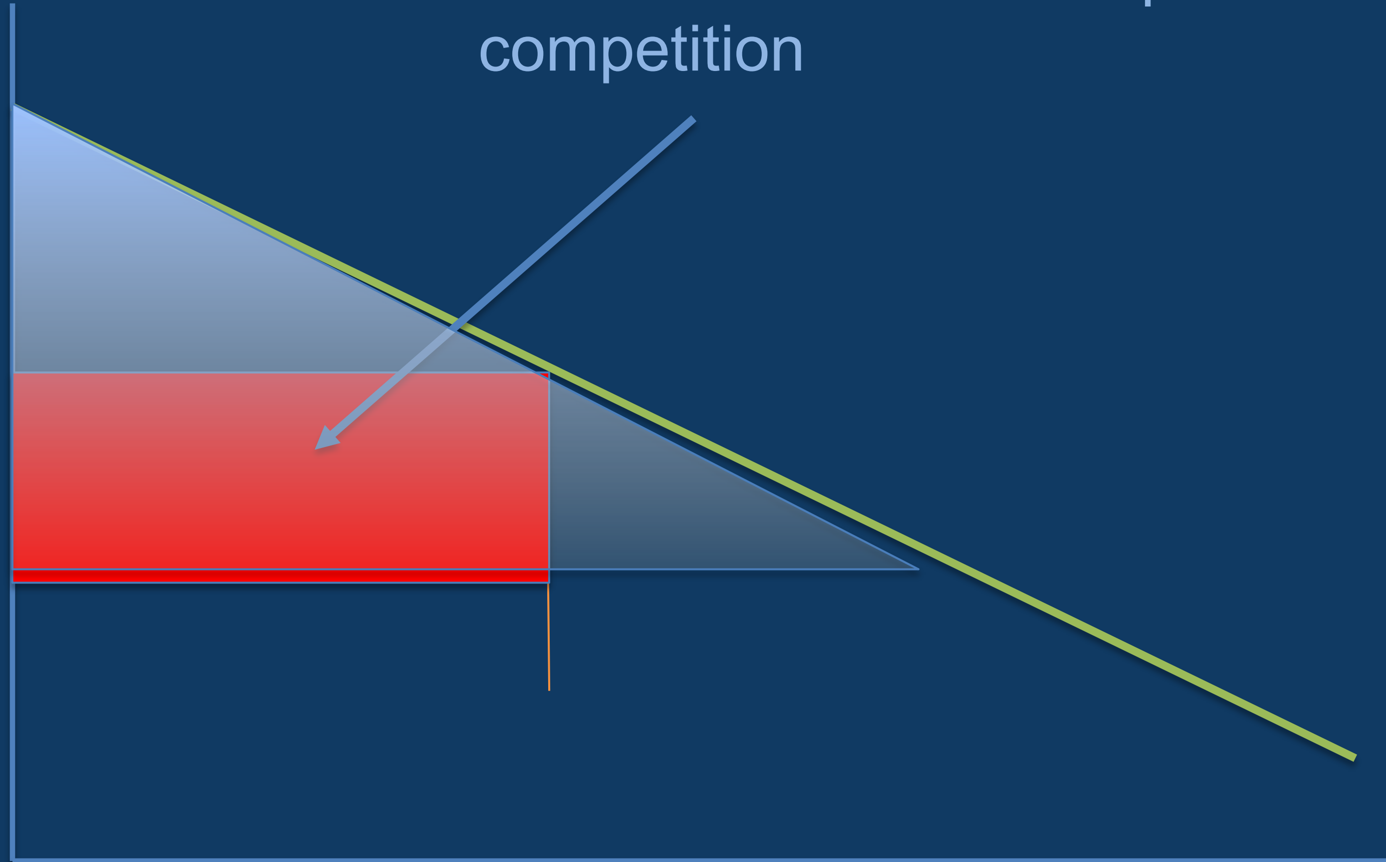
Competitive price

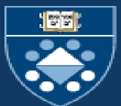


The monopoly quantity is lower than the competitive quantity

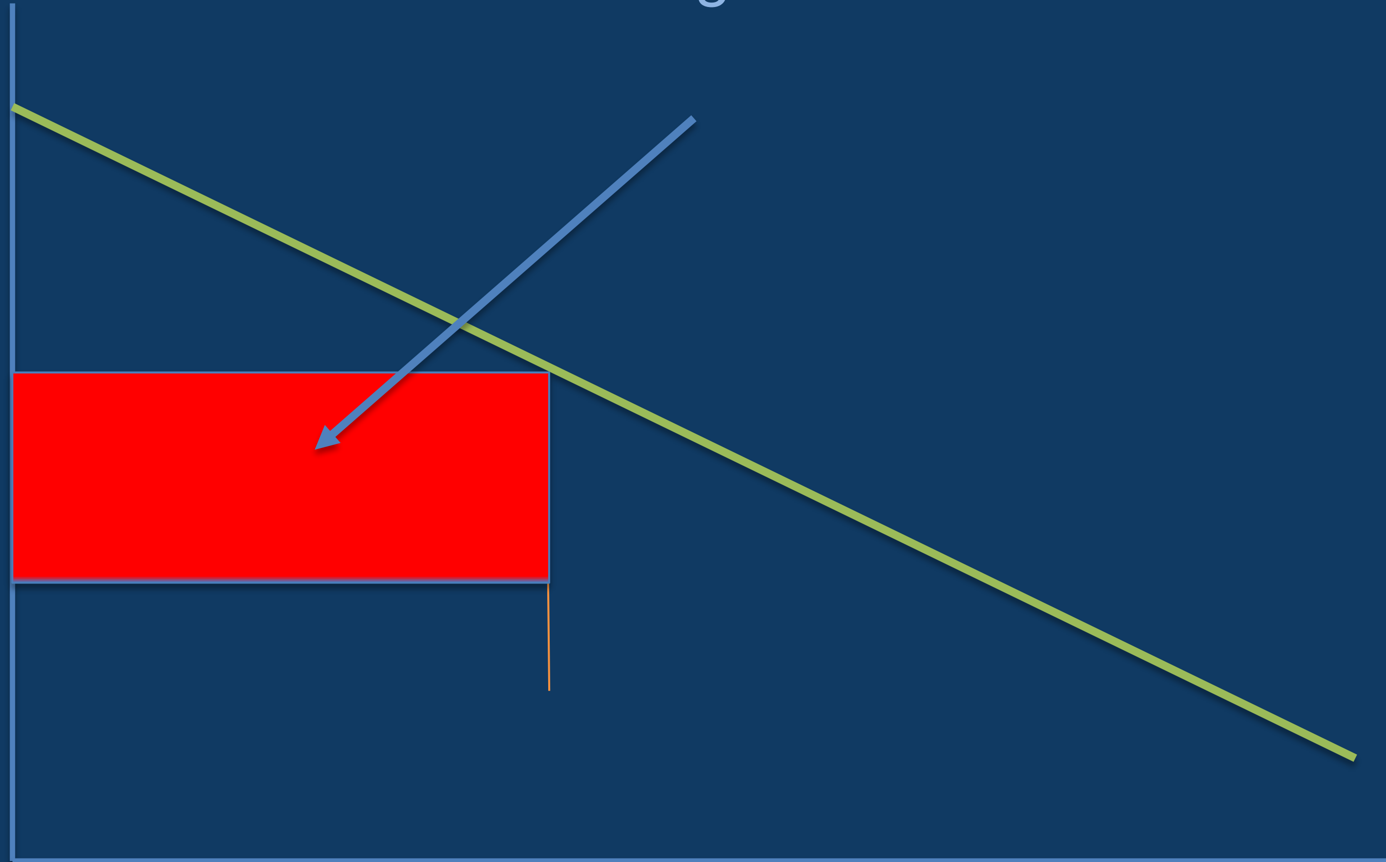


Profit gained for monopolist that would be consumer surplus under competition





Very desirable profit!
How to get it?



There are three strategies that firms can try that increase their profits in a way that harms consumers.

- Collude: competitors all agree that each one will charge the monopoly price. This results in the monopoly quantity (Q / n per symmetric firm). This tactic is prevented by the Sherman Act s1.

- Merge: the competing firms could simply merge together and in that way form a monopolist that could charge monopoly price and earn monopoly profit. This tactic is prevented by the Clayton Act s7

- Monopolize: A large firm uses its existing power to drive out / down competitors, thereby allowing it to charge closer to monopoly price. This tactic is prevented by the Sherman Act s2. Monopolization is the hardest, most sophisticated, hard to distinguish success on the merits from bad behavior if only look at e.g. market share.

Markets are Highly Concentrated

Percent Highly Concentrated (HHI>2,500) 2010-2016

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2010 2011 2012 2013 2014 2015 2016

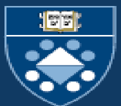
Hospitals

Specialist physicians

Insurers

Primary care physicians

Source: Fulton, B., Health Affairs, 2017, 36:9, 1530-1538



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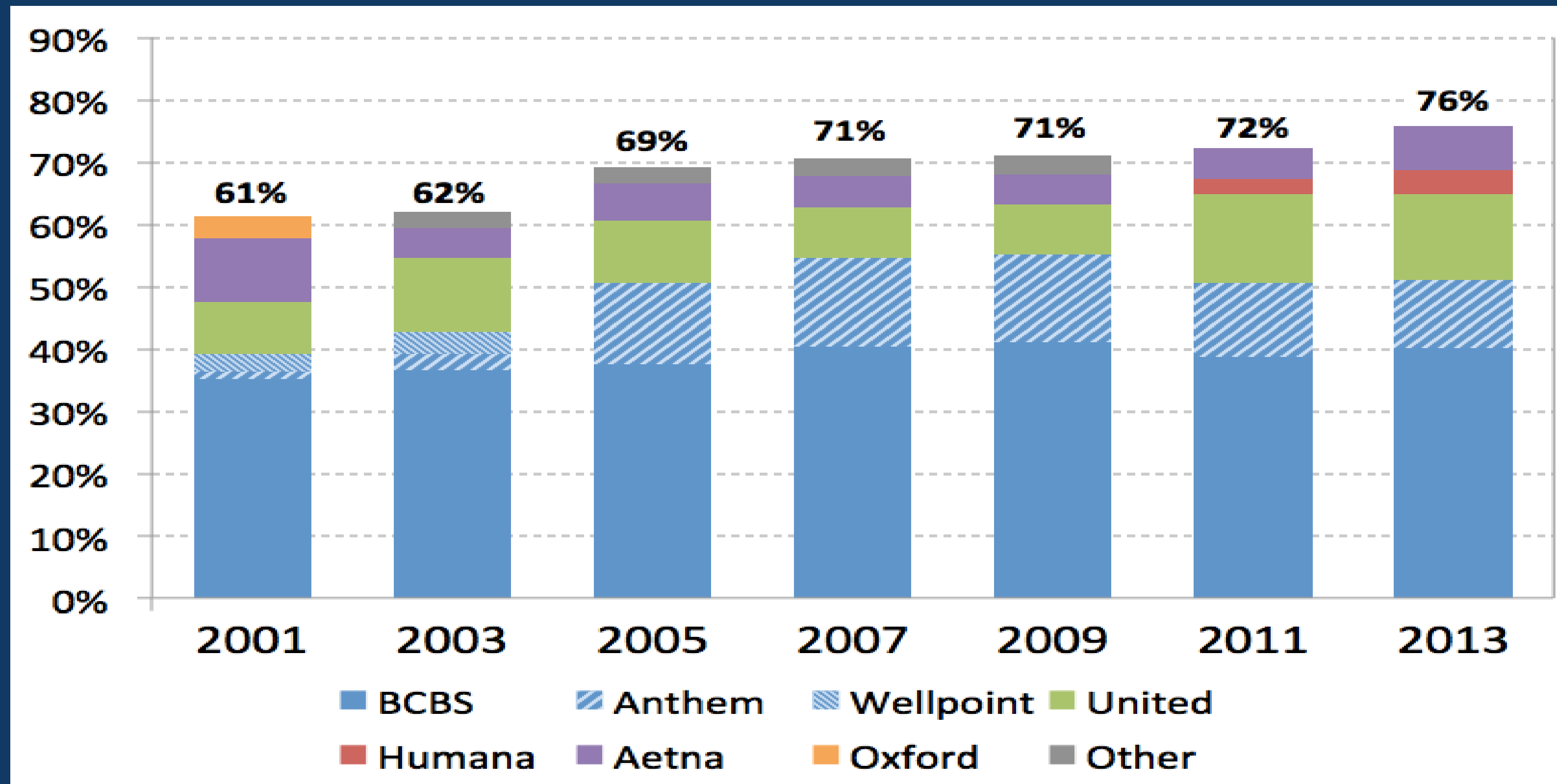
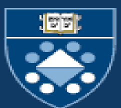
Insurer Consolidation

- 57 to 69% of MSAs highly consolidated in 2016
- 4 insurers had 76% of the national, fully insured commercial market in 2013
- 2 largest insurers had 70% market share in 2014 in 1/2 of MSAs





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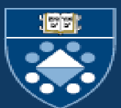
Market Share of Top 4 Insurers, Fully-insured Commercial
Source: NAIC & CCIIO. Excludes California. Courtesy Leemore Dafny

Hospital Consolidation

- Nearly 1,600 hospital mergers in the past 20 years (1998-2017)
  - 456 mergers in most recent 5 years (2013-2017)
- Most urban areas now dominated by 1 or 2 large hospital systems

Year	Number of Deals	Number of Hospitals
98	139	287
99	110	175
00	86	132
01	83	118
02	58	101
03	38	56
04	59	236
05	51	88
06	57	249
07	58	149
08	60	78
09	52	80
10	72	125
11	93	160
12	107	242
13	88	293
14	99	175
15	102	265
16	89	241
17	78	216

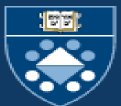


Physician Practice Consolidation

- Nearly 31,000 physician practice acquisitions by hospitals 2008-2012 (Venkatesh, 2019)
  - Over 55 percent of physicians are in hospital owned practices
  - Hospital acquisitions of physician practices driving most consolidation in physician services market

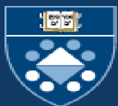
- Practice size growing
  - 80% of physicians in practices of 10 or less in 1983; 61% in 2014
  - % in solo practice: 40% in 1983, <20% in 2014

- Markets for specialist physicians highly concentrated; markets for primary care physicians becoming more concentrated
  - 65% of Metropolitan Statistical Areas (MSAs) highly concentrated for specialists, 39% for primary care physicians



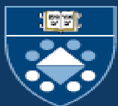
Enforcement of hospital mergers

- Known to be a problem; decades of antitrust enforcement
- Now we have well developed empirical tools
- The FTC wins cases
  - Cannot challenge all mergers, resource intensive
  - States are not well-positioned to enforce the rest / smaller mergers
- COPA is the new strategy
  - Good states: Massachusetts Health Policy Commission
  - Bad States: West Virginia
- State enforcement is political and will not always generate the best outcome for consumers



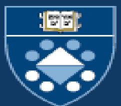
Enforcement of physician-hospital mergers

- Mergers have been driven, in part, by the Medicare fee schedule, which paid higher rates for procedures performed in hospital-owned locations.
- The economics literature provides theories of how VI could shift the nature of competition in upstream and downstream markets
- No economist has been able to demonstrate an increase in the quality of care due to vertical integration (despite a lot of collective effort)



Potential harm to competition from hospital acquisition of physician practices

- If a hospital acquired a sufficient number of physician practices, the acquiring hospital could narrow physician referrals in their region and hence gain bargaining **leverage** with insurers over their own prices.
    - VI may also create incentives for physicians to raise hospitals' profits by recommending more, or more expensive, hospital-based treatments.
- VI also permits a physician to carry out the very same procedure in the very same location but bill as a hospital. We call this regulatory **arbitrage**.
- VI allows a hospital to create various incentives for its affiliated physicians to refer patients to the hospital for services. This change in **steerage** ability gives the hospital the power to foreclose competitors



Empirical evidence

There is empirical evidence that changes in VI are associated with increases in Medicare and commercial health spending.

- Regions with increases in VI had increases in commercial health spending and Medicare fee-for-service spending.
- County-level increases in VI are associated with increases in both county-level provider prices and commercial health spending.

Evidence…

There is also evidence that VI can affect acquired physicians' prices.

- Capps et al show that changes in VI (measured with providers' tax IDs) cause an increase in acquired physicians' prices of 14%. They observe that a large portion of this price increase is driven by differences in site of care reimbursement rates.

There is also evidence that VI can affect hospital prices

- Chernew et al find that vertically integrated physicians tend to refer to a narrower group of providers. This could provide acquiring hospitals additional bargaining leverage. Research finds that after VI, there is a small but significant 3-5% increase in hospital prices.

Physician practice consolidation

- Horizontal mergers of physician practices
- Small numbers (small transaction size) can still represent market power
  - All the obstetricians in a city or town
  - Most of the anesthesiologists in a region
  - Large share of primary care physicians
  - Etc
- Clearly below the FTC’s radar
- But can create significant market power → increases bargaining power with insurers
- Allow physicians to demand price increases

CT problem

- A state level understanding the impact of VI and HI on health spending and provider prices
- …and understanding if those changes are driven by market power (bargaining leverage (HI and VI) or steerage (VI only))…
- is vital as, historically, most hospital acquisitions of physician practices escaped antitrust scrutiny because the individual transactions were under HSR merger reporting thresholds so the FTC has not been analyzing them or enforcing against them.

[The Hart-Scott-Rodino Antitrust Improvements Act of 1976 (Section 7A of the Clayton Act) requires firms to provide pre-merger notifications to antitrust authorities regarding acquisitions exceeding a threshold dollar value. In 2021, that threshold is $92 million]

CT policy tools

- Two of the VI problems can be addressed by state antitrust enforcement
  - Leverage: market power lets combined entity bargain for higher prices
    - Harm to consumers
  - Steerage: market power lets combined entity direct patients to itself and away from rivals
    - Harm to consumers and rivals

  - Arbitrage: federal regulations create a mechanical incentive to merge

Other CT policy options

- Advance notification
  - Data reporting required
- Health Policy Commission type body
  - Analysis
  - Publication of magnitudes, data, issues
  - Forecast impact on spending
  - Creation of transparency and common knowledge is critical
- Review state laws to ensure sufficient
- Consider ways to insulate from political influence