

Antitrust After Managed Care

Thomas (Tim) Greaney

Once upon a time and a very good time it was, advocates for market based approaches to health policy had a coherent story to tell. Cost and quality would continue to be suboptimal as long as fee for service medicine persisted and the myriad of market imperfections that impede market efficiency went unchecked. Things could be righted however by adopting principles associated with managed care, together with pursuing sensible antitrust enforcement and government deregulation to clear away private and regulatory underbrush obstructing market forces. Economic theorists and policy experts agreed that these steps would effectively address market imperfections and begin to glue together the pieces of our fragmented delivery system. And, for a while, things seemed to work out as promised. Providers began to reorganize into firms or other integrating arrangements and health insurers adopted financial and contractual measures designed to align provider incentives with consumer needs. Regulators directed policies at removing obstacles to competition and antitrust enforcers sought to encourage efficient consolidation while blocking cartels and oligopolistic markets. Spiraling costs leveled off and both payment and organizational structures began to adapt to market forces.

But things changed. A powerful backlash against managed care led to both a retrenchment by insurers in the practices that worked and a regulatory environment that curbed abuses but also undermined some of the methods managed care had used effectively. Managed care and the competition-enhancing practices it had begun to spawn-- integration and rivalry-- unraveled. Today the health care system is in a state of flux, with third party payors backing off management of utilization and bargaining over price. The new industry watchword, “consumer directed health care” signifies that consumers will shoulder responsibility for making comparisons on the price, intensity and quality of services they receive. So far, the outcome for consumers of insurance and patients have been less than encouraging. Insurance costs have increased, as premiums risen and co-payments have escalated dramatically.¹ Furthermore, reports on health quality and efficacy of service continue to tell a sobering tale of error and dysfunction.²

¹ For a thorough, albeit largely critical, analysis of consumer directed health care see Timothy Stoltzfus Jost, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER DRIVEN MOVEMENT* (2007).

² One widely noted and startling recent finding was that patients received recommended care in only 55% of their encounters with providers for thirty chronic and acute conditions and some preventative practices. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 *New Eng. J. Med.* 2635 (2003). A large literature documents the enormous variation in clinical care practices and costs without any corresponding differences in quality. See John Wennberg & Cooper, *Dartmouth Atlas of Health Care* (1997). In its landmark reports, the Institute of Medicine has documented the severe shortcomings of care in hospitals. See Institute of Medicine, *Crossing the Quality Chasm*. See also, Alliance for Quality Care, National Institute for Health Care Management and Robert Woods Johnson

Against the backdrop of markets that appear dysfunctional and the weakening of managed care, antitrust law in health care has begun to lose coherence. Some standard economic principles may be called into question in consumer markets; others may require considerably more detailed factual analysis to apply them accurately in specific cases. Consequently some of antitrust law's norms and assumptions must be adapted to evaluate accurately the economic effect of conduct and market structures. At present, neither legal doctrine nor fact finding techniques, presumptions or precedent give much guidance in how to deal with these changes. An unfortunate fallout of the current state of affairs is that the capacity of competition to improve consumer welfare is seriously doubted in many quarters with the result that judges and policy makers are increasingly reluctant to endorse standard antitrust rules or to adopt regulatory schemes that promote competition.

After providing some background on the economics of health care and venturing a few thoughts on why managed care came to be undone, this article will attempt to take stock of the current state of competition policy and explore why the highly ambiguous current state of affairs undermines development of coherent antitrust policy. It concludes with some doctrinal paths and factual benchmarks for improving antitrust inquiries in consumer directed health care markets.

I. The Health Care Marketplace: Dealing with Market Failure and Related Conundrums

Since Kenneth Arrow's seminal 1963 essay, economic analyses have properly focused on the significant market failures that beset healthcare markets. Arrow's principle culprits, "uncertainty in the incidence of disease and in the efficacy of treatment," information asymmetries between patient and physician, and the "nonmarketability of the bearing of suitable risks" still collude to prevent optimal resource allocation. Though differing to some extent in the severity which they attach certain of these failures and the extent to which social institutions may rectify problems, health economists uniformly stress that information, agency and insurance vastly complicate applying microeconomic principles to analyze the welfare effects of transactions or policy changes.³ While the causes of market failure may be defined in several ways, four factors appear to have the greatest impact: information deficits, product differentiation, agency relationships, and insurance market imperfections.

Foundation, Treatment of Severe Chronic Illness. What Explains Cost and Quality Differences? Kaiser Family Foundation, www.kffnetwork.org (Sept. 2007)

³ A leading text summarizes market failure in health care as follows:

"Health markets fail to satisfy the substantial list of requirements that must be met to be classified as perfectly competitive: large numbers of consumers and firms, free entry and exit, marketability of all goods and services including risk, symmetric information with zero search costs, and no increasing returns, externalities, or collusion. While health markets satisfy none of these requirements fully, they fail the requirements of symmetric information, zero search costs, and the marketability of all products most dramatically.

David Dranove & Mark A. Satterthwaite, The Industrial Organization of Health Care Markets, in 1B HANDBOOK OF HEALTH ECONOMICS 1093, 1095 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000)

First, asymmetries in information and uncertainty as to diagnosis, treatment, and outcome are critical to understanding the health care marketplace. A variety of circumstances undermine the neoclassical assumption that buyers and sellers possess adequate information to assess the quality and costs of the services provided. Because of the technical nature of medical information and the complexity of diagnoses and treatment alternatives, patients and third-party payers find it difficult to evaluate the cost and quality of health services. Indeed, the considerable uncertainty that attends medical treatment makes judgments on causation (and hence costs and benefits of the treatment) difficult. In addition, information is asymmetrically distributed among providers, patients, and payers. This characteristic may permit physicians to induce demand for their services; and at a minimum it makes information costly for buyers to acquire.

Second, product differentiation among physicians and hospitals along a number of dimensions is widely recognized.⁴ Hospitals vary widely based on quality, reputation, geographic location, amenities, and other features. Likewise, physicians are differentiated by their training, reputations, locations, hospital affiliation, and many other aspects. On the demand side, the heterogeneous preferences of consumers are manifest, with varying preferences or "tastes" for travel, amenities, reputation, and "caring" service. These preferences interact with heterogeneous product characteristics in health services to contribute to reducing substitutability among providers of essentially the same services.⁵ The quality of services sold by health care providers also may vary considerably, depending upon the professionals' talents, training, attention to interpersonal relationships, communications skills, and other factors. Product differentiation that grows out of the heterogeneity of consumer preferences is a source of market power in health services markets.⁶ Finally, sellers of health services are subject to impediments to mobility, both in the form of regulatory entry barriers imposed by governmental licensure and private certification and practice requirements, and switching costs such as those resulting from steep learning curves and changing technology.

Third, agency relationships, which pervade health markets, are highly influential

⁴ Martin Gaynor & William B. Vogt, Antitrust and Competition in Health Care Markets, in 1B HANDBOOK OF HEALTH ECONOMICS 1410-12 (A.J. Culyer & J.P. Newhouse eds., 2000); Seth Sacher & Louis Silvia, Antitrust Issues in Defining the Product Market for Hospital Services, 5 INT'L J. ECON. BUS. 181 (1998).

⁵ See Gaynor & Vogt, *supra* note xx, at 1411.

⁶ See *id.*

It is th[e] combination of a heterogeneous product with heterogeneous preferences which is key [T]his bestows the seller with market power. Patients choose sellers who produce the type of services and have characteristics that best match their preferences. The fact that patients choose sellers who give them the highest utility gives sellers market power, since switching to another seller will reduce a patient's utility. *Id.* See also Mark Satterthwaite, Consumer Information, Equilibrium Industry Price and the Number of Sellers, 10 BELL J. ECON. 483 (1979).

in health care transactions.⁷ A large majority of consumers (patients) purchase health care through multiple agents--their employers, the plans or insurers chosen by their employers, and the physicians who guide patient choice through referrals and selection of treatment modalities. For most employees, choice is limited to a small number of plans because most small employers offer only one plan and large employers rarely offer more than three. The number of plans and benefits offered by each employer is strongly affected by the possibility of risk selection and the employer's transaction costs in administering health plan coverage. Thus, to some extent, the employer acts as an agent for its employees in purchasing health insurance, choosing plans that afford the mix of quality, price, and geographic coverage that best suits most of its employees. This multiplicity of agents greatly complicates antitrust analyses of consumer behavior and is a principal source of market failure in health care.⁸

Health insurance markets also exhibit conditions that give rise to market failures. Moral hazard, for example, refers to the overuse of medical care resulting from the fact that insurance lowers the cost of each purchase for insureds. Overuse causes inefficiency as insured individuals purchase more services than they would if they had to bear the entire cost; hence, true marginal costs exceed marginal benefits. Risk selection also may undermine health insurance markets. That is, insurers have strong incentives to seek a favorable, or low-risk, pool of insureds. Acting on that incentive can cause an unraveling of risk spreading as the sick and the healthy become divided into different market segments. By the same token, adverse selection may occur as patients switch plans and adjust coverage according to anticipated needs.

A further issue of concern is the incorporation of analyses of quality into health care antitrust litigation. "Promoting quality" has often been advanced to justify professional restraints of trade and for anticompetitive mergers. For the most part, courts have followed the lead of the Supreme Court and adopted a working assumption that cartels harm quality, or certainly do not improve it enough to justify price or output restraints. Although one circuit court has endorsed a "quality of care" defense, most courts have rejected such arguments on factual and legal grounds. While appropriately skeptical about self serving claims by physicians that their conduct is motivated by patient care concerns,⁹ enforcers and courts may have neglected to consider the quality

⁷ Lawrence Casalino, *Managing Uncertainty: Intermediate Organizations as Triple Agents*, 26 J. HEALTH POL., POL'Y & LAW 1055, 1055-57 (2001).

⁸ See Casalino, *supra* note xx, at 1061-62; Gaynor and Vogt summarize the multiple agent relationship: "In practice hospital choice is a complex combination of the consumer's choice of health plan, the health plan's choice of providers to contract with, the consumer's choice of physician, and the consumer-physician-health plan choice of whether and where to admit the consumer." Gaynor & Vogt, *supra* note xx, at 1431

⁹ The FTC/DOJ Report on Competition in Health care the agencies skepticism as follows: "Enhancing quality" has long been the invariant excuse of providers who engage in anticompetitive conduct....There are almost always more narrowly tailored means of achieving the same quality improvements without employing the anticompetitive means selected by self-interested providers." Dose of Competition at 1-28.

dimensions of health market transactions.¹⁰ Indeed, several prominent scholars have questioned whether antitrust courts have given enough attention to the impact of nonprice competition.¹¹

Finally, perhaps more than in any other industry sector assessments of health care markets need to take cognizance of the teachings of behavioral economics. Questioning the predictions of rational choice theory, behavioral economists suggest that individuals do not always act in ways the rational choice theories predict. Drawing from the findings of other disciplines, such as psychology, neuroscience, and sociology, behavioral economists note that a sizeable percentage of their test subjects systemically deviate from these rational choice theories' predicted outcome in several important ways: (1) bounded rationality; (2) bounded willpower; and (3) bounded self-interest.¹² Individuals confronting decisions involving complexity and ambiguity are particularly likely to adopt heuristics that are likely to result in nonoptimal outcomes, at least in terms of their

¹⁰ In a comprehensive review of federal antitrust cases, Professors Sage and Hammer have concluded that “courts seldom engage in detailed assessments of quality and non-price concerns;... no cogent theory of nonprice competition has been developed to guide courts in specific cases; courts ... divorce quality from competition rather than factoring it into a competitive mix; [and] courts under-utilize analytical tools that are available to them from other disciplines, such as health services research.” William Sage & Peter Hammer, *A Copernican View of Health Care Antitrust*, 65 *L. & Contemp. Probs* (2002)

¹¹ See William Sage & Peter Hammer *Competing on Quality of Care: The Need to Develop a Quality of Care Policy for Antitrust*, 32 *U.Mich. J. L.Ref.* 1069 (1999)(“ While economists have long recognized the complexities of non-price competition, antitrust courts typically employ simpler models of competition based on price and output, either ignoring quality as a competitive dimension or assuming that it will occur in tandem with price competition. This approach allows courts to condemn anticompetitive practices that result in higher prices and lower quality, but places situations where consumers are getting more but paying more, or paying less but getting less, outside their analytic reach.”). See also, Kristin Madison, *Hospital Mergers in an Era of Quality Improvement*, 7 *Hous. J. Health L. & Pol’y* 265 (2007)(“[A]ntitrust opinions that address hospital mergers often use the term “quality” but rarely analyze it”).

¹² One author offered the following catalogue of “anamolies” growing out of bounded rationality:

loss aversion (namely having significantly greater concern about losing a given amount than in the utility of gaining the same amount);

the endowment effect (when we demand much more to give up and sell an object than what we would be willing to pay to acquire that object);

status quo bias (when the choice of default option impacts the outcome);

framing effects (the way the choice is framed--such as a sure gain or avoiding a loss--alters the way we decide);

availability heuristic (when we assess the probability of an event by asking whether relevant examples come readily to mind);

representative heuristic (when we ignore the "base rates and overestimate the correlation between what something appears to be and what something actually is");

overconfidence bias (when we believe that good things are more likely (and bad things less likely) than average to happen to us); and

hindsight bias (our tendency to overestimate the ex ante prediction that we had concerning the likelihood of an event's occurrence after learning that it actually did occur).

Maurice E. Stucke, *Behavioral Economics at the Gate: Antitrust in the Twenty First Century*, 38 *Loy. U.*

Chi. L. Rev. 513 (2007); See also, Russell B. Korobkin & Thomas S. Ulen, *Law & Behavioral Science:*

Removing the Rationality Assumption from Law & Economics, 88 *Cal. L. Rev.* 1051, 1053 (2000);

Christine Jolls et al., *A Behavioral Approach to Law & Economics*, 50 *Stan. L. Rev.* 1471 (1998).

expected utility.¹³ The fit of the insights into the conduct of providers and patients is particularly apt in health care where patients have been shown to be subject to various biases and apply heuristics that tend to lead to decisions inconsistent with those predicted by rational choice theory.¹⁴

II. Antitrust Law's Role in Promoting Competitive Norms

The Early Years: 1970-80

The early years of antitrust enforcement were marked by efforts to break down institutionalized barriers to competition, such as medical ethical norms that prohibited physicians from engaging in competitive contracting and organizational arrangements that obviated competitive interactions such as provider controlled insurance plans. In addition, government enforcers challenged cartelization schemes that sought to bar entry by HMOs and obtained injunctions against mergers that threatened to turn hospital markets into single firm monopolies or tight oligopolies.¹⁵ As Clark Havighurst and others have characterized the antitrust revolution, litigation served to undermine unstated assumptions that medical care was not “trade or commerce,” that health professionals should be given elbowroom that other commercial actors did not enjoy, and that institutions including hospitals and insurance plans might be structured in a manner that served professional ends.¹⁶

Betting on the Come: 1980-85

It is therefore somewhat understandable that the markets in which the early antitrust cases were brought often lacked price competition or meaningful negotiation over the quality and costs of health services. Not only did the challenged practices and institutions inhibit the play of competition but government regulations such as certificate of need laws and hospital rate regulation directly interfered with competition among providers. Further, both public and private financing of health care was predicated on

¹³ Russell Korobkin, Cal. L. Rev.

¹⁴ Richard G. Frank, *Behavioral Economics and Health Economics* NBER Working Paper 10881(2004); *The Health Care Challenge: Some Perspectives from Behavioral Economics* (working paper 2005)

¹⁵ See Thomas L. Greaney, The Vulnerable Revolution, 5 Yale. J. Reg 179 (1988)(predicting competition in health care would not succeed if regulatory and infrastructure did not support it); Clark C. Havighurst, The Contributions of Antitrust Law to a Procompetitive Health Policy, in MARKET REFORMS IN HEALTH CARE 295 (J. Meyer ed. 1983).

¹⁶ See e.g., Havighurst, *American Health Care and the Law—We Need to Talk!* 19 Health Aff. 84, 91 (2000)(Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) “effectively overturned the policy view that professionals could be trusted to determine the basic rules under which health care was provided. Its effect was suddenly to make health care competition mandatory...); see also, Blumstein, Professional Paradigm, Cornell L. Rev.

“reimbursing” providers for the “cost” of their services, a practice referred to as “fee for service” (FFS) medicine. This methodology—an outgrowth of provider control of payment systems and the compromise reached to assure acceptance of Medicare and Medicaid programs—created a system that exerted little discipline on unit pricing and rewarded providers that increased volume of services. FFS medicine thus had the troubling effect of distorting incentives in a manner wholly antithetical to what would be expected under competitive conditions. Rather than seeking to lower input costs and achieve an efficient balance of price and quality for their services, physicians and hospitals (and ultimately suppliers of technology and products) were free to set their own parameters.¹⁷

In many of the challenges to hospital mergers, especially the five cases brought in the early 1980s, fee-for-service payment still predominated. Under these conditions, a plausible economic case existed that mergers would not lessen competition. In the absence of payer-driven competition, it was unlikely that the merger would enhance the merged hospital's ability to raise price. A number of hospital pricing studies during the era preceding managed care competition indicated that hospitals were able to charge supracompetitive prices regardless of market structure. Moreover, nonprice competition may have had adverse welfare effects during the pre-managed care era. The economic literature indicating that a "medical arms race" occurred where hospitals lacked sufficient market clout to counteract physician demands for equipment and expanding capacity suggested that greater market concentration would improve matters by reducing expenditures on marginally useful equipment and amenities.¹⁸

The FTC itself acknowledged that in aggressively challenging hospital mergers despite the absence of significant price competition, it was betting on the come:

[E]ven assuming that the limited price competition that does exist in these markets may produce only marginal benefits in terms of overall consumer welfare, the antitrust laws will endeavor to protect this price competition, if, for nothing else, the hope that price competition will be enhanced.¹⁹

¹⁷ Several economic models of physician behavior attempted to explain physician pricing behavior given the absence of price competition. Cite demand inducement and target income hypotheses and critiques.

¹⁸ See e.g., Monica Noether, *Competition Among Hospitals*, 7 J. Health Econ. 259 (1988); James C. Robinson & Harold S. Luft, *Competition and the Cost of Medical Care, 1972 to 1982*, 257 J. Am. Med. Ass'n 3241 (1987); James C. Robinson & Harold S. Luft, *The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care*, 4 J. Health Econ. 333 (1985); George W. Wilson & Joseph M. Jadow, *Competition, Profit Incentives, and Technical Efficiency in the Provision of Nuclear Medicine Services*, 13 Bell J. Econ. 472 (1982). For reviews of this literature, see Hammer, supra note 14, at 22-27; Frederic J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 Wake Forest L. Rev. 107, 153-67 (1994); and Paul A. Pautler & Michael G. Vita, *Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?*, 10 J. Contemp. Health L. & Pol'y 117, 123-29 (1994).

¹⁹ American Med. Int'l, 104 F.T.C. 1, 180, 198, 204-05 (1984); See also, Hosp. Corp. of Am., 106 F.T.C. 361, 482-84, 512 (1985) ("It is clear that Section 7 protects whatever price competition exists in a market, however limited.").

While merger law requires a forward-looking perspective, one can also find in the case law and policy pronouncements the aspiration that antitrust enforcement against professional restraints of trade²⁰, cartels,²¹ and networks²² would improve the vigor of price competition. Notably, many of these decisions were predicated at least in part on the belief that managed care would supplant fee for service medicine.

As Peter Hammer argues, while nonprice competition motivated by consumer preferences embodied in the market demand function is likely to increase social welfare, nonprice investments are only designed to steal business from rivals the positive benefits they bring to consumers may yield a net welfare loss.²³ That is, in some circumstances such as when price competition is stymied, the marginal cost of such services may exceed their marginal benefits. “[W]hile consumers value nonprice amenities, they do not necessarily value them at a level where they would be willing to pay the full cost of the amenity if they had a choice. These risks are especially prevalent in today’s “consumer directed” health care markets in which market failures are left largely untouched.²⁴ In these circumstances, restricting nonprice competition increases total welfare.

The Rise and Fall of Managed Care: 1990-2000

At the outset of the decade, most observers heralded managed care as the solution to spiraling costs and a guarantor of quality. The Clinton health reform proposal made managed care the centerpiece of a comprehensive federal program designed to reshape the structure of health care insurance and delivery in America. After the demise of the Clinton Plan, most states chose not to adopt wide-ranging reforms. Managed care was credited with success in containing costs. With increased reliance on risk sharing by providers and selective contracting, the need for efficient means of delivering services was apparent and “integration” became the watchword of the industry. Providers integrated horizontally and vertically and various forms of integrated delivery systems appeared in almost every community. For most policymakers and economic analysts, this was a natural progression toward rationalizing a delivery system long out of touch with market forces. Legal doctrine began to accommodate these changes. Judicial decisions and administrative rules in diverse areas including ERISA, antitrust, malpractice, tax-exemption, fraud and abuse and Medicare law reflected a consensus that provider cooperation and integration was necessary in the new era of managed care.

²⁰ In re AMA, 94 F.T.C. 701 (1979), modified and enforced, 638 F.2d 443 (2d Cir.1980), aff’d, 455 U.S. 676 (1982).

²¹ Cite FTC boycott cases involving HMOs in early 80’s

²² Cite early PPO cases and advisory opinions.

²³ Hammer, *Antitrust Beyond Competition*, 98 Mich. L. Rev. 849, 864.

²⁴ Hammer at xx:

(“Given the multiple failures in medical markets--imperfect information, moral hazard, agency problems--competition may lead to a level of nonprice rivalry that exceeds what is socially desirable, driving a wedge between the socially optimum equilibrium and the competitive equilibrium.”).

The gears of legal and institutional change shifted abruptly in the mid-nineties, however. Growing dissatisfaction among consumers and providers with the constraints imposed by managed care, together with legal regimes that seemed to protect payors from accountability, fostered the so-called “managed care backlash.”²⁵ A torrent of state legislation targeting the shortcomings of managed care was quickly enacted. At the same time, many of the institutional arrangements that had grown up to support the new world of provider and payor integration began to fall apart. For example, “disintegration” of unsuccessful PHO’s, bankruptcies of IPAs, and unwindings of mergers became commonplace. Finally, many of the legal doctrines that had previously supported managed care were reexamined: judicial and administrative law developments reflected increasing skepticism about the practices and performance of the industry.²⁶

During this period extraordinary consolidation occurred in hospital and insurance markets. Owing in part to defeats in federal court litigation, lax antitrust enforcement and judicial antipathy to managed care,²⁷ concentration grew significantly in almost all sectors of health care delivery and payment. Research demonstrates that hospital consolidation in the 1990s raised overall inpatient prices by at least five percent and by 40 percent or more when merging hospitals were closely located.²⁸ Anecdotal evidence suggests that payers in many local markets faced increased resistance to bargaining by hospitals and that this led to higher prices.²⁹

How the Antitrust’s Narrative Relied on Managed Care

A close look at the antitrust-healthcare interface over the last twenty years reveals a narrative that rested heavily on the success of managed care competition. Both the government’s antitrust enforcement agenda in health care and the resulting legal doctrine and its underpinnings—its presumptions, rules of thumb and factfinding proclivities-- relied on assumptions of a well functioning market driven by managed care

²⁵ A large literature has developed on the managed care backlash, *see, e.g.*, Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 Ind. L. Rev. 395 (2001); David Mechanic, *The Managed Care Backlash: Perceptions and Rhetorician Health Care Policy and the Potential for Health Care Reform*, 79 Milbank Q. 35 (2001); Alain Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. Health Pol., Pol’y & L. 931 (1999); Marc A. Rodwin, *Backlash As a Prelude to managing Managed Care*, 24 J. Health Pol., Pol’y, & L. 1115 (1999); Alain C. Enthoven, *Consumer Choice and the Managed Care Backlash*, 27 Am. J. L. Med. 1 (2001).

²⁶ See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Policy in Health Care*, 21 Health Affs. 185 (March/April 2002)(discussing influence of backlash on judicial decisions in antitrust).

²⁷ See Greaney, *Whither Antitrust*, *supra* note xx

²⁸ See Robert Woods Johnson Foundation, The Synthesis Project, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care* (Feb. 2006). Simulation Studies show increases of 53 percent (Gaynor and Vogt); Event studies 40 percent and Structure-Conduct Performance (SCP) studies 4–6 percent (Keeler et al. Capps et al.)

²⁹ Center for Study of Health Systems Change (periodic survey of competitive conditions in 12 markets).

contracting. Much precedent stresses the importance of—and often explicitly seeks to preserve—competitive bargaining through managed care entities. The cases discussed below illustrate that the enforcement agencies and the courts tended to view provider-payor negotiations and competitive contracting as the fulcrum for assuring efficient price competition. As discussed above, this was an entirely appropriate stance to take, as there was and is little in economic theory or the nation’s experience before managed care to suggest that competition without managed care would served consumer welfare.

Over the last twenty five years the antitrust enforcement agencies have devoted a staggering amount of their resources to health care—by some accounts more than to any other industry. What is notable for purposes of this article is that the lion’s share of these efforts were directed at promoting competition by preventing providers from obstructing managed care or assuring that the structure of provider markets and networks was conducive to competitive bidding. In challenging physician price fixing, boycotts and network abuses, the FTC and DOJ have brought over one hundred federal court cases and administrative complaints, have issued over 40 advisory opinions, issued and revised policy statements and dozens of speeches.³⁰ The agencies have also aggressively pursued hospital mergers, challenged insurance company consolidations, physician mergers and payor abuses of their market power. Finally the FTC has devoted extensive resources in the past five years to dealing with abuses of intellectual property in the pharmaceutical industry, challenging agreements that kept generic drugs from entering the markets of brand name rivals and mergers and abuses of the patent system designed to improperly obtain or maintain monopoly power. The antitrust enforcement agenda aimed at

Preserving the structure of hospital markets based in large part on evidence of the effect of concentration on hospital prices, usually evidenced by the effect on managed care contracting.

Preventing price fixing, sham networks, or other abuses by unintegrated physician networks,

Challenging payor practices of dominant third party payors such as most favored nations clauses, that had exclusionary effects on entry by smaller rivals

Challenges to mergers between health insurers that threatened dominance of managed care markets

A closer look at these cases and consent decrees reveals that the courts and agencies relied heavily on presumptions and evidentiary shortcuts that emphasized the central role of managed care bargaining. For example, conventional structure-conduct - performance model was applied so that provider concentration was treated as leading to higher prices or reduced quality. The mechanism of managed care competition was shown empirically to control against provider induced demand and limit hospital discretion over price and volume. In addition the Agencies’ Policy Statements were explicitly designed to promote network competition. Finally, the agencies relief was designed to promote or preserve network viability.

³⁰ See Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 *Hous. J. Health L. & Pol’y* 189 (2007)

III. The Demise of Managed Care and Ascendancy of Consumer Directed Health Care

As indicated earlier, managed care came into disfavor in many (but certainly not all) parts of the country. Why did the backlash occur? A variety of explanations have been proffered. Some attribute the phenomenon to the fact that HMOs and other managed care organizations were the first entities to take responsibility for the financing and delivery of patient care and therefore stood to be held responsible for the system's shortcomings. No comparable entity, much less a corporate for profit firm existed under fee for service medicine to shoulder the burden of responsibility.³¹ Others attribute adverse reaction to managed care to the mix of high- and low-risk enrollees in the same plan:

The initial enrollment of low risks in managed care plans increased premiums in non-managed care plans to the point that higher risks were willing to enroll in managed care plans. The mix of low and high risks in managed care plans left the low risks unhappy with increasing premiums and the high risks unhappy with the management of care.³²

Another contributor to the fall of managed care was regulation. States imposed literally thousands of regulatory limitations such as defining medically necessary care, requiring external reviews, mandating access to certain providers and restricting financial incentives. The extent to which these laws impeded managed care's growth or inhibited its effectiveness is not clear, but they certainly affected the path and force of the backlash.³³

What has filled the void? While managed care has not disappeared, many of its most important tools such as capitated payments, selective contracting, and vertical integration, have fallen into disuse.³⁴ In its place "consumer directed health care" has emerged as the most rapidly growing form of coverage. To be sure, that catch phrase covers a lot of ground. Under one usage it refers to the general shift of responsibility for choice and cost to consumers.³⁵ Relying increasingly on large co-payments, deductibles and various benefit designs, insurance plans offer benefits packages that create incentives for consumers to take more responsibility to choose the nature and intensity of health services and providers who provide that care. Beyond the trend toward higher deductibles and co-payments, "consumer directed" plans sometimes are linked with health reimbursement accounts (HRAs) which are dedicated funds supplied by employee and/or employee contributions that can be used to pay for certain medical expenses.³⁶

³¹ Zelman and Berenson, Health Affairs

³² Dowd (summarizing Pauly and Nicholson), Health Affairs

³³ See Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. Health Pol. Pol'y & L. 427 (2005); Peter Jacobson, St. L. U. L.J

³⁴ Robinson, Health Affairs.

³⁵ See John Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 St. Louis U. L. J. 397 (2003); Jost supra note xx.

³⁶ See Paul Fronstin & Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Survey 2006: Early Experience with High-Deductible and Consumer-Driven Plans*, EBRI Issue Brief No. 300 (Dec. 2006), available at:

http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3769. See generally Wendy K.

One rapidly growing variant, the health savings account (HSA), carries with it important tax benefits such as allowing taxpayers to exclude from taxable income funds placed in an HSA, provided that it is coupled with a high deductible health plan (HDHP).³⁷

The concept is sharply distinguishable from managed care. Consumer directed health plans are designed to make patients more cost-conscious by forcing them to pay for a portion of their care and moving the locus of decision-making to the consumer and away from managed care entities.³⁸ Patients will have strong incentives to economize on routine care up to the attachment point of their deductibles, and will make individualized purchasing decisions based trade-offs based on their wealth status and preferences and assessments of need. The focus on consumer choice places extraordinary reliance on price shopping driving health markets, a result that reorients the mechanisms for price competition in the market and, as will be argued, neglects the problems that plague patient shopping for care.

Consumer Directed Health Care's Inability to Rectify Health Market Imperfections

Looked at from the standpoint of economic efficiency, a central failing of consumer directed health care is that it is designed to remedy only one form of market imperfection: the moral hazard problem—the distortion that causes individuals to consume more care than they would if they confronted the true cost of their care.³⁹ It does so largely by correcting demand side incentives through large deductibles that require enrollees to spend a substantial amount of their own money before their insurance policy begins to

Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485 (2004) (describing consumer-driven plans and arguing that they effectively ask patients to ration their own care) [hereinafter *Can Consumer-Choice Plans Satisfy Patients?*]. See also Gary Claxton et al., *Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest*, 25 HEALTH AFF. Web Exclusive W476 (Sept. 26, 2006),

³⁷ See Revenue Ruling 2002-41, 2002-28 I.R.B. 75 (employer's contribution to HSA is not taxable if funds are used to pay certain medical expenses). See also, and Melinda Beeuwkes Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, HEALTH AFF. Web Exclusive w516, w518 (Oct. 24, 2006); Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J. L. & MED 395 (2005).

³⁸ See, e.g., Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, HEALTH AFF. May 28, 2003, at W3-237, W3-239 (“The popular ‘consumer-driven’ or ‘defined contribution’ models are no more than a cover for high deductibles, intended to make consumers cost-conscious shoppers.”), at <http://content.healthaffairs.org/cgi/reprint/hltaff.w3.237v1.pdf>. See also Buntin, *Consumer-Directed Health Care*, (reporting on studies showing that people who enroll in high-deductible consumer-directed plans are healthier and have higher incomes than those who remain in more traditional plans); U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *CONSUMER-DIRECTED HEALTH PLANS: EARLY ENROLLEE EXPERIENCES WITH HEALTH SAVINGS ACCOUNTS AND ELIGIBLE HEALTH PLANS* (2006) (younger and higher income federal employees joined CDHPs in the Federal Employees Health Benefits Program).

³⁹ Bryan E. Dowd, *Coordinated Agency Versus Autonomous Consumers in Health Insurance markets*, 24 Health Affs. 1501, 1509 (2005). Although high-deductible plans are common in the individual health insurance market, they have not been widespread in the policies offered to employees of large firms.

pay.⁴⁰ Examining the health economics literature, one is hard pressed to find an economic argument that consumer price shopping unassisted by intermediaries or government controls will serve consumer welfare better than other means of arranging health care financing.⁴¹

Experience in markets in which consumers have borne the burden of shopping without insurance coverage gives strong support to those who question the efficiency of CDHC. There are many reasons to suspect that consumer directed health care markets will be suboptimal. As Mark Hall and Carl Schneider succinctly summarize it, “[T]he market for uninsured medical services is a calamity.”⁴² Patients are woefully uninformed about services and prices; have strong ties to their doctors (and it is the doctors who decide what services to use); lack the knowledge and in many cases the inclination⁴³, to shop for better prices or services. In practice, the mechanics of patient-provider “contracting” for services is also highly deficient: hospitals and physicians insist patients agree, ex ante, to pay all “fees” or “charges” under circumstances in which neither party knows what the costs will be, let alone what alternatives in price or service exist elsewhere. As Uwe Reinhart offered the following pointed analogy to explain the defects in consumer shopping for health services:

Suppose, purchases of shirts by individuals were partly prepaid from collective funds assembled for large groups of shirt purchasers, although the individual buyer might also have to pay a part of the price. Suppose next that prospective buyers of shirts were led into a store stocked with boxes marked "Shirt." The consumer would have free choice of boxes, although only the most vague idea of what actually was in each of the myriad of boxes. ... Once a box with a shirt in it had been accepted by the consumer, he could not return it for a refund. A month or so after having received the box, the buyer would be sent a nearly indecipherable statement whose only comprehensible line is: Pay \$56.95. It is only then that the buyer knows what the shirt has cost him or her. The shirt, by the way, may or may not fit.

With few exceptions, economists are highly skeptical about the efficiency of health care pricing in the health care marketplace. Describing the market for hospital prices, as ad hoc, without any external constraints”, Reinhart finds “no method to this

⁴⁰ See, e.g., Herzlinger, note xx *supra*; Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6(3) J. of ECONOMIC PERSPECTIVES 321 (1992).

⁴¹ See Dranove et al, *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 34 J.L. & Econ. 179 (1993); Dranove & Satterthwaite *supra*; Gaynor & Vogt, HANDBOOK OF HEALTH ECONOMICS

⁴² Mark A. Hall and Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643, 645 (2008).

⁴³ See Judith Hibbard & Edward Weeks, *Consumerism in Health Care*, 25 Med. Care 1019.

madness.”⁴⁴ The absence of effective price information in the market is well chronicled. Few physicians or hospitals make their prices easily available and consequently search costs for individual consumers are quite high. Less widely appreciated, however, is the fact that effective price shopping seems likely to remain a daunting task for many services. This is because patients buy services in bundles, and often the components of that bundle are not known *ex ante*; moreover, even the well educated patient does not know what she will need before diagnosis.⁴⁵

Scholarship closely examining the physician-patient relationship adds to the evidence that disintermediated transactions by patients are not well designed to advance consumer welfare. As explained below, one important set of issues is raised by behavioral economists who find a number of factors that impact demand and supply side decision-making. Patients acting under conditions of stress and subject to risk aversion many affect willingness to seek treatment, obtain information and optimally choose health care treatments.⁴⁶ Consumers faced with increasing complexity in making choices among complicated alternatives may adopt heuristics that ill serve effective decision making. Behavioral economists have also raised a host of issues regarding physician decision-making, noting the propensity of physicians to fall prey to availability heuristics (salience) and overconfidence biases.⁴⁷ In this environment, in which uncertainty abounds, doctors and patients come to adopt mechanisms for communication that are in many ways unique and quite distinct from the buyer seller model.⁴⁸ Further, the doctor-patient relationship is one in which confidence, vulnerability and trust predominate.⁴⁹

Consumer directed health care is also subject to some inherent contradictions that undermine its ability to satisfy consumers and maximize allocative efficiency. Its design largely limited to affecting decisions regarding routine care is poorly suited to dealing with the seriously ill that drive cost increases in insurance.⁵⁰ Likewise, given that under CDHC physicians are likely to continue to exert strong influence over the decisions of their patients, they are ill-suited to make price-benefit comparisons, as they know little about the financial needs and assets of their patients.⁵¹

⁴⁴ Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 *health Affs.* 57 (2006).

⁴⁵ As Hall & Schneider put the shopping patient’s dilemma:

[P]atients dislike asking about prices and have trouble even when sturdy enough to try. Even if patients could be given estimates, only patients who knew what they needed could benefit. But who knows that before visiting the doctor? Even doctors often can’t predict treatments. 106 *Mich. L.Rev.* at 658.

⁴⁶ Koszegi, *Health, Anxiety and Patient Behavior*, 22 *J. Health Econ.* 1073 (2003). See generally, Richard G. Frank, *Behavioral Economics and Health Economics* (2004) working paper (update citation)

⁴⁷ Rabin, *Psychology and Economics*, 36 *J. Econ. Lit.* 11 (1998); Frank *supra*.

⁴⁸ The classic work in this area is Jay Katz, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

⁴⁹ Mark A. Hall, *Law, Medicine and Trust*, 55 *Stan. L. Rev.* 463 (2002)

⁵⁰ Elhauge at 374 (“consumer driven care... will do nothing to reduce the incentives to overconsume care for the seriously ill that drive the lion’s share of health care costs”). See also James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 *JAMA* 1880 (2004).

⁵¹ See Jost, *supra* note xx at yy.

In sum there are myriad reasons to doubt that consumer shopping under the incentives created by high deductible plans will allocate health care resources efficiently. Whether legal regimes will recognize these deficiencies is an open question, although several commentators suggest that courts are likely to adopt interpretations of contract, tort and regulatory laws that respond to some of the deficiencies of CDHC.⁵²

IV. Antitrust in a Post-Managed Care World

So far I have argued that the logic and economic underpinnings of antitrust in health care have been closely tied to a vision of markets that are disciplined and ameliorated by managed care agency. Evidence from the litigated cases and economic studies supported the proposition that managed care reversed the “medical arms race” among hospitals and incentivized physicians to integrate practices and economize to reduce costs. With insurers taking a far more passive role, the driving force for price competition has been substantially lessened. CDHC, the foregoing analysis suggests, raises “second best” issues as to whether it offers improvements in some aspects of the market under consumer directed markets will improve social welfare.⁵³ In light of these doubts about the capacity of CDHC to enable effective competition in health care markets, questions arise about the appropriate path for antitrust law and enforcement policy.

A. Flashpoints at the Antitrust-CDHC Intersection

If the history of health care in the United States teaches us anything, predictions about the future of health care markets are fraught with peril. However, if the current trend toward disintermediation and consumer directed care continue, competition will assume a different trajectory and consequently antitrust analysis will be altered as well. One likely change, already underway, is a shift in the balance of power. With third party payors and employers less actively involved in selecting and deselecting providers and bargaining over price and quality, studies have shown that providers have generally gained the⁵⁴ upper hand in bargaining with payers. There is evidence that the efforts of providers to adopt new techniques for controlling cost, such as pay for performance strategies, network tiering, etc. although still in their early stages, are ill equipped to result in comprehensive cost control.⁵⁵

⁵² See Jacobs; Hall & Schneider supra; Jost supra.

⁵³ See Mark Schlesinger, Editor’s Note, *Markets as Belief Systems and Those Who Keep the Faith*, 31 J. Health Pol., Pol’y & L. 417, 420 (2006) (criticizing the DOJ/FTC Report, A Dose of Competition for ignoring Second Best problems in advocating application of antitrust principles to health care markets and offering predictions “based on no empirical evidence at all”; concluding that “claims that more competitive markets will necessarily leave consumers better off are almost universally wrong”). See generally, THOMAS RICE, *THE ECONOMICS OF HEALTH CARE RECONSIDERED* (1998); Robert Evans, *Reconsidering the Role of Competition in Health Care Markets*, 25 J. HEALTH POL., POL’Y & LAW 889 (2000).

⁵⁴ Center for Study of Health Systems Change;

⁵⁵ See Meredith Rosenthal et al., *Pay for Performance in Commercial HMOs*, 355 N Eng. J. Med. 18, 1895 (2006); Lawrence Casalino et al., *General Internists’ Views on Pay-for-Performance and Public Reporting of Quality Scores: A National Survey*, Health Affairs 26, no. 2; (2007): 492-499; Cannon, Pay for Performance, Yale J. Reg.

Some forms of antitrust abuse may decline under CDHC. Assuming relatively toothless payer controls over price and volume of services, provider cartels directed at payers may decline, as the impetus among providers to gain countervailing power by forming networks is likely to diminish. Less subject to the demands of managed care entities, physicians face fewer economic incentives to fix prices vis a vis third parties. Likewise, consolidations of hospitals and other service providers will less often be driven by a desire to enhance their bargaining power vis a vis payers. There is however a cloud to this silver lining: an unfortunate corollary of disintermediation is that providers will be less motivated to integrate their operations clinically or to achieve scale and scope economies demanded in efficiently functioning competitive markets. This is not to suggest that provider cartelization will disappear. To the extent that providers feel competitive pressure at all in a consumer directed environment, they will be disposed to block access to patients using the tools of the pre-managed care era. Hence, one might speculate that disputes over staff privileges, credentialing, professional guidelines and professional society membership may resurface.

Second, leaving consumers to their own devices in selecting providers and choosing the intensity of services they will receive sharply exposes the problems associated with agency, imperfect information and behavioral peculiarities of individuals' health decision making. Physicians are likely to have relatively unconstrained influence over patients' choices and selection of complex services will be driven by cost or nonprice dimensions such as amenities rather than cost effectiveness of those services. In this context, several issues familiar to health care antitrust litigation may be exacerbated. For example, in defining markets for physician and hospital services, courts have applied Merger Guidelines and critical loss analysis to predict where consumers would travel or which services they would substitute when faced with price increases. These analyses have fallen prey to what one economist calls the "silent majority fallacy" in failing to appreciate the heterogeneity of patient demand for care.⁵⁶ Interpretation issues are likely to be even more problematic where financially significant cost sharing decisions are left to consumers and in which the decisions are unique to each service offered by providers.

Third, an open question (dating back to Arrow) is whether intermediaries and nonmarket institutions will emerge to effectively assist consumers in dealing with information and agency problems. In the pre-managed care era these organizations and professional norms were thought to be helpful to ameliorate uncertainties, but in practical application they often served professional rather than consumer interests.⁵⁷ Consumer protection safeguards are likely a necessary corollary to the success of these

⁵⁶ CORY S. CAPPS ET AL., THE SILENT MAJORITY FALLACY OF THE ELZINGA-HOGARTY CRITERIA: A CRITIQUE AND NEW APPROACH TO ANALYZING HOSPITAL MERGERS (NBER Working Paper No. 8216, Apr. 2001) See generally, Greaney, Chicago's Procrustean Bed, supra .

⁵⁷ Paul Starr, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE

organizations. As Averitt and Lande's analysis of consumer protection safeguards suggests, consumer protection laws (which they define and characterize as occurring "inside the head" of the consumer), are a natural complement to antitrust law in that both address market failure and are a necessary condition to assuring consumer choice and efficiently functioning markets.⁵⁸

Finally, legislatures and regulators are unlikely to sit still when problems surface. As was seen in the extraordinary legislative response to managed care in the 1990s, politicians of all political stripes do not hesitate to dictate the terms of health care financing and delivery when consumer complaints surface. Regulatory intervention seems even more probable in the emerging era of health reform, in which many states may providing subsidies for individuals to purchase health insurance, and in some cases may act as the insurer of last resort themselves. At this juncture it is impossible to predict what response the problems likely to arise in the consumer directed era are likely to generate. However, history suggests that demands for service mandates, price controls or access requirements.

B. Antitrust Doctrine in the New Environment

So, what do these changes augur for competition policy in health care? Initially it may be observed that disintermediation increases the complexity and indeterminacy of antitrust inquiries in health care. Managed care enabled courts to employ helpful simplifying assumptions and evidentiary shortcuts. Thus the testimony of payers often provided important data on which courts could base analyses of competitive effects, market definition and market power. For example, evidence that payers would "play off" one hospital against another supplied proof in numerous merger cases that the merger would likely lessen competition and in unilateral effects cases that market competition was particularly intense between the merging parties. Likewise testimony by payers regarding their perceptions of the likely response of their insureds to price increases offered a gauge of the elasticity of demand, the effect of hypothetical price increases, and the degree of product differentiation in the market.

But beyond the increasing complexity of assessing competitive effects and markets, the shift to CDHC has more profound implications for antitrust policy. As argued above, given the peculiar economics of the health care industry, it is at least debatable whether competition will necessarily advance consumer welfare in the absence of managed care. One response therefore might be to abandon the enterprise of promoting competition and endorsing a government-sponsored payment system that controls the price and volume of services, while leaving consumers free to choose among plans that operate within parameters set by the government.⁵⁹ This option obviously would require a legislative tsunami that does not seem to be on the horizon. Since that storm would also effectively eradicate antitrust policy in health care, we will declare it beyond the scope of this article.

⁵⁸ Lande & Averitt *supra*.

⁵⁹ See Timothy Stoltzfus Jost, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER DRIVEN MOVEMENT* (2007)

The most salient question for antitrust enforcement and policy is how to accommodate the market peculiarities likely to emerge (or resurface) under consumer directed health care. At the outset it should be noted that antitrust doctrine has traditionally taken markets as it finds them. It has not been uncommon for antitrust tribunals to decide cases involving markets distorted by regulation, market imperfections and unpredictability. In these instances, antitrust courts generally assume the market is doing the best it can to advance consumer welfare, leaving it to legislatures to fix undesirable aspects of competition if they see fit. At the same time, however, antitrust precedent has increasingly demanded accurate appraisals of market conditions including accommodating the real world impact of market imperfections in the analysis of restraints of trade and consolidations. For example, free riding in vertical restraint cases, transaction costs impeding effective negotiations, information deficits impacting consumer decision making, externalities in R&D and natural monopoly conditions have impacted antitrust appraisals. Where market failures undermine the working assumptions of microeconomic theory, they cannot be ignored.

Further, the Supreme Court's most recent foray into the health care-antitrust area strongly signaled that courts should closely evaluate market conditions to test the applicability of conventional antitrust principles.⁶⁰ Indeed *California Dental Association v. FTC* can be read to mandate that where plausible claims of market imperfections require investigation before applying conventional antitrust norms and rubrics.⁶¹ While the Court unfortunately muddied the waters as to how to apply the rule of reason and quick-look methodologies, and its treatment of the evidence at hand is highly questionable, it nevertheless took an important step forward in placing market failure at the center of antitrust analyses in health care cases. Overturning the FTC's condemnation of a ban on advertising of dental services, the majority was troubled by questions about the capacity of consumers to understand professional advertising and the fact that the case arose "in a market characterized by striking disparities between the information available to the professional and the patient." The Court remanded, insisting that lower courts tailor their inquiries under the rule of reason to meet the specific circumstances before them. In the context of a dental services market in which information was poorly understood and susceptible to abuse, this signaled that factfinders must closely examine

⁶⁰ *California Dental Association v. FTC*, 526 U.S. 756 (1999). In earlier cases the Court treated informational market failures inconsistently. In *Jefferson Parish Hospital District No. 2 v. Hyde*, the Court reversed the Fifth Circuit's holding that patients' "lack of complete information regarding the quality of medical care offered" supported an inference that a hospital with 30 percent market share possessed market power. While conceding that market imperfections in the market might indirectly "impede competition on the merits," it found that such "abstract" market power was not "the kind of market power that justifies condemnation of tying." Just eight years later, however, in *Image Technical Services, Inc. v. Eastman Kodak*, the Court reached the seemingly inconsistent conclusion that deficits in consumer information and switching costs largely attributable to imperfect information could support a finding that the defendant possessed market power in the aftermarket for its products. See Michael Jacobs

⁶¹ See Clark Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL., POL'Y & LAW 939, 953 (2001); Greaney, *Procrustean Bed*, supra note xx.

market imperfections before reaching conclusions about the competitive consequences of conduct or market structure.⁶²

The threshold issue concerns antitrust doctrine. Does antitrust law have sufficient flexibility to deal with the imperfect competition this article forecasts under CDHC? Several doctrinal options are available to deal with market failure. It should be noted that none command a strong pedigree in the case law, as prior to California Dental courts have rarely been called upon to specifically address these issues. Nevertheless, each finds some support in the expanding scope of economic inquiries endorsed by contemporary antitrust analyses.

Intramarket Second Best Analysis.

A somewhat radical departure from standard antitrust analysis would be to apply what has been referred to as “intramarket second best analysis” to situations in which market failures exist. Taking a cue from the General Theory of Second Best,⁶³ which teaches that where there are multiple market failures there is no guarantee that remedying one will improve efficiency (and indeed could actually harm efficiency), Peter Hammer suggests that antitrust law should entertain a defense that recognizes the possibility that acts that seemingly violate antitrust standards may nonetheless advance total welfare.⁶⁴ To do so tribunals would have to undertake an evaluation of the total welfare effects of alleged restraints of trade or consolidation that might lessen competition, attempting to determine whether the total social benefits exceed costs, including effects on both static and dynamic efficiency.⁶⁵ A commonly cited example is restraints of trade or monopolization of the cigarette market. Cigarette consumption is subject to a significant market failure—negative externalities—in that buyers do not internalize the significant social costs of their consumption. These costs are born by society in the form of public expenditure on health insurance and the harmful effects of second hand smoke. From an allocative efficiency perspective, overconsumption results and resources are devoted to

⁶² The risk that California Dental would be interpreted as encouraging deference to professional judgments and running the risk of promoting perceived “good consequences” or “worthy purposes” over close analysis of the economic consequences of conduct has been noted but the more persuasive reading is that the court was insisting on careful appraisals of economic conditions, and not reversing its several pronouncements that reject special treatment for professional services. See National Society of Professional Engineers; Indiana Federation of Dentists.

⁶³ Lipsey & Lancaster, *The General Theory of Second Best*, 63 *Rev. Econ. Stud.* 11 (1956). Some scholars have argued that second best theory bars exclusive reliance on the allocative efficiency norm in antitrust. Lawrence Sullivan, *Book Review*, 75 *Colm. L. Rev.* 1214; See also Richard S. Markovitz, *The Limits to Simplifying Antitrust*, 63 *Tex. L. Rev.* 41 (1984); but see Oliver Williamson, 127 *U. Pa. L. Rev.*

⁶⁴ Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 *Mich. L. Rev.* 849 (2000).

⁶⁵ Under Professor Hammer’s proposal, the intramarket second best analysis would proceed as follows:
[D]efendants ... would have to establish ...: first, that the alleged anticompetitive conduct remedies an identifiable market failure or market failures; second, that the conduct will result in a net increase in total welfare (static efficiency); third, that the conduct will not substantially impair the ability of public or private actors subsequently to ameliorate the effects of the market failure (dynamic efficiency); and finally, that there is not a less restrictive alternative consistent with the antitrust laws that the parties could undertake to achieve similar welfare gains.

Id. at 882.

the production of cigarettes. Under an intramarket second best analysis, a cartel or monopolist that raised price might increase social welfare by reducing consumption of cigarettes.⁶⁶

Application of the defense in a hospital merger case illustrates some of the difficulties associated with this defense. As explained by Professor Hammer, defendant hospitals would first have to document market failures that frustrate price competition and encourage nonprice competition; next hospitals would be required to prove that “merging would result in a net increase in social welfare (static efficiency).”; and third that the merger would not “undermine the ability of public and private actors to address the underlying market failures (dynamic efficiency)” through means such as greater integration of financing and delivery of care in the private sector or improved methods of government contracting.⁶⁷ While conceptually sound, the defense would require courts to undertake some unrealistic burdens. First they would be required to estimate the “costs” of nonprice competition, which themselves do not lend themselves to direct measurement.⁶⁸ Next factfinders would need to estimate whether these reductions in competition “increase total welfare and result in a more efficient distribution of resources”, again an exercise for which only crude guesses would be feasible. Finally, the proposal would demand that the court speculate as to whether private or public solutions were “unlikely to emerge in [the] market in the foreseeable future.”⁶⁹

The upshot of this analysis may be that nonprice rivalry does not necessarily result in efficient outcomes. As Peter Hammer argues, while nonprice competition motivated by consumer preferences embodied in the market demand function is likely to increase social welfare, nonprice investments are only designed to steal business from rivals the positive benefits they bring to consumers may yield a net welfare loss.⁷⁰ That is, in some circumstances such as when price competition is stymied, the marginal cost of such services may exceed their marginal benefits. “[W]hile consumers value nonprice amenities, they do not necessarily value them at a level where they would be willing to pay the full cost of the amenity if they had a choice. These risks are especially prevalent in today’s “consumer directed” health care markets in which market failures are left largely untouched.⁷¹ In these circumstances, restricting nonprice competition increases total welfare.

⁶⁶ See Hammer at 862-3. A more complex analysis is needed to determine whether other societal measures such as taxes are preferable to allowing cartelization or monopolization. See Brodley xx

⁶⁷ Id. at 890.

⁶⁸ Id.

⁶⁹ Id.

⁷⁰ Hammer, *Antitrust Beyond Competition*, 98 Mich. L. Rev. 849, 864.

⁷¹ Hammer at xx:

(“Given the multiple failures in medical markets--imperfect information, moral hazard, agency problems--competition may lead to a level of nonprice rivalry that exceeds what is socially desirable, driving a wedge between the socially optimum equilibrium and the competitive equilibrium.”).

A Market Failure Defense

An alternative to the intramarket second best analysis would be to recognize a market failure defense to restraints of trade and to incorporate market failure analysis into structural analysis in merger and joint venture cases. This approach, as advanced by this author and others, would recognize that where “offsetting a market failure promotes competitive results”⁷² antitrust tribunals must evaluate the full effects of conduct and structure to accurately apply antitrust law to health care markets. There are several doctrinal pathways to performing this analysis. The inquiry might be performed as part of a full rule of reason inquiry, with the analysis focusing on a complete weighing of procompetitive effects and anticompetitive harms.⁷³ Another formulation finds room under a fully articulated ancillary restraint framework, albeit subject to rigorous proof standards.⁷⁴ Others have advocated recognizing the defense in the context of evaluating efficiency justifications for joint ventures that advance innovation or improve productive efficiencies,⁷⁵ and excusing price fixing arrangements where substantial and irremediable externalities exist.⁷⁶ An important distinction from the intramarket second best analysis is that this approach would ask courts only to make informed judgments about the competitive impact of conduct—a subject about which their experience and “economic common sense” can provide a guide—and not require an impossible calculation of total welfare effects.

In addition, each of the authors proposing a market failure defense is careful to insist on qualifications before that defense can be successfully advanced. The list of requirements for the defense is a tacit acknowledgement of the uncertainty of the enterprise and the risk that if left unstructured, it might grant an invitation for excessive judicial discretion. The following criteria are several that detail and confine the scope of the inquiry while also recognizing the need to consider dynamic efficiency and alternatives.

Specifying the market failure. Recognizing that an open-textured market failure defense might subvert the long line of cases refusing to extend special treatment to the health care industry and could foster a resurgence of cartel practices in the medical profession, the defense should be confined to imperfections that have a serious distortive effect on market outcomes.⁷⁷

⁷² Areeda at para. 1504.

⁷³ Areeda supra note xx (the investigation would require examining “redeeming virtues” of correcting market imperfections as “procompetitive factors” under the rule of reason.

⁷⁴ Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 *Conn. L. Rev.* 605, 627 (1989)

⁷⁵ Joseph F. Brodley, *The Economic Goals of Antitrust: Efficiency, Consumer Welfare, and Technological Progress*, 62 *N.Y.U. L. Rev.* 1020 (1987)

⁷⁶ Christopher R. Leslie, *Achieving Efficiency Through Collusion: A Market Failure Defense to Horizontal Price Fixing*, 81 *Cal. L. Rev.* 243 (1993)

⁷⁷ See 2A AREEDA ET AL., supra note 8, ¶ 406b, at 31 (describing costs of enforcement efforts directed at market failure and concluding “so long as departures from ‘ideal conditions’ are modest or relatively short-lived, it would not be worthwhile to try to correct all of them ... There are at least presumptive grounds for attacking all price-fixing cartels but not for attempting to correct modest structural departures from perfect competition.”).

Requiring Proof that removing market imperfection improves competitive outcomes. Proponents of a market failure defense would for the most part require that the kind of restraint or structural change proposed is of a kind, based on experience with similar conduct or structures, which has been shown to improve the competitiveness of markets.

Evaluating alternative remedies and considering effect of defense on dynamic efficiency. Even if a restraint has market-improving propensities, it is still necessary to assess the risk that it might be abused or contribute new anticompetitive conditions to the market. The market failure analysis would require courts to determine, using the analytic paradigm for ancillary restraints, whether the restraint is necessary to achieve the claimed benefits and whether its scope is no broader than necessary to realize those objectives.

Incorporating Market Failure into Antitrust Analysis

A third step in dealing with the new environment is one that requires no doctrinal innovation and should be the least controversial for those concerned with accurate economic appraisals: Courts and antitrust enforcement agencies should recognize and evaluate market imperfections in making assessments of markets and effects. Judges, including some of the most ardent advocates for incorporating economic analysis into antitrust jurisprudence, have often failed to observe and assess the peculiar economic conditions in health markets before them. Important decisions involving hospital geographic market definition, hospital product market definition, cartelizing activities and payers exercising market power have overlooked the significance of market imperfections in their analysis.⁷⁸ Whether these cases occurred too early in the antitrust learning curve or evidence a judicial distaste for managed care, history suggests that courts might be slow to appreciate the subtleties of market impediments to effective competition under consumer directed health care. Nevertheless, some of the critical determinants of competitive effects, including market definition and demand responses to price and quality signals require close attention to market imperfections. As outlined below, the key task is paying close attention to how patient/consumers and providers respond to market signals

C. Analyzing Imperfect Markets : Some Guidelines

The task of dealing with consumer directed market is undeniably daunting. Courts and antitrust agencies will need to assess transactions and structures in which consumers with highly heterogeneous demand confront heterogeneous sellers competing in markets far more fragmented than today's. Bundled purchasing (e.g. hospital services, diagnostic testing and procedures) are likely to be less common; consequently prices and output will be harder to discern. Many of the elements that behavioral decision theory predicts will influence consumer choices will play an especially important role in patient purchases of health services. Similarly, as argued above problems associated with agency

⁷⁸ See Greaney, *Antitrust's Procrustean Bed* supra note xx (summarizing courts' neglect of market failure analysis in antitrust litigation involving mergers, market definition and cartelization cases).

and imperfect information deficits when no longer ameliorated by third parties are likely to increase. Finally, “upstream” cartel and monopoly problems—such as those involving generic drug competition, pharmacy benefit managers and group purchasing organizations-- are likely to affect consumer directed markets even more severely if insurers are not active purchasers. The following guideposts may help clarify the task at hand.

Demand Side Analysis

We have seen that under CDHC demand for health services will take on new character as consumer/patient’s preferences will likely have scant assistance from payers or employers. This change compels factfinders to closely consider the nuances of how consumers make their choices in health care markets under conditions of uncertainty, dependence, anxiety, and reliance on trusted providers.⁷⁹ The burgeoning literature of behavioral choice theorists should help guide antitrust analyses of consumer demand in a number of areas. For example, the response of consumers to a small but significant increase in price—the benchmark for market definition analysis under the Merger Guidelines—entails judgments that implicate consumers’ diverse preferences and bounded rationality. This will necessitate an approach that takes markets as they are and appreciates that health services markets are themselves highly differentiated. For example, consumer responses to SSNIPs in markets for routine care, chronic care, and major surgical interventions are likely to vary significantly as price elasticity will reflect differing effects of the behavioral factors mentioned above and influences of physician agents. As elsewhere in antitrust, sophistication comes with a cost: BHT will add to the complexity of litigation and counseling.

On the other side of the coin consumer information deficits and behavioral patterns may give rise to plausible justifications for information-related restraints of trade. Antitrust law has dealt with a number of cases involving advertising, professional society standards of practice and guideline dissemination, and certification. These cases have generally involved relatively modest efforts to improve information, though courts have sometimes failed to consider the full range of possible harms resulting from collective professional judgments.⁸⁰ In general the case for efficiency benefits from improving information flows to consumers should be even more compelling under CDHC and courts will likely give great leeway to such efforts. Of concern however is whether such efforts should be permitted given the possibility that alternatives

Supply Side Issues

VI. Conclusion

⁷⁹ See Hall & Schneider, *supra* n. xx at 650-51 (analyzing effects of illness on “patient as consumer”)

⁸⁰ See e.g., Koefoot; Sachar; See generally, Greaney, *Quality of Care Defense*, *supra* note x.

The trend toward disintermediation and the rise of CDHC have begun to reshape the competitive dynamic of most health care markets. While managed care has not disappeared, there is little question that the tools that held the most promise for promoting efficiency in health care have fallen into disuse and that consumers are increasingly being asked to shoulder responsibility for making choices about the cost and quality of care they receive. Although antitrust policy is sufficiently flexible to take into account the changing relationships, the doctrinal tools for doing so are not fully developed. Moreover, antitrust tribunals will have to grapple with extraordinarily complex factual issues surrounding the demand for health care without the benefit of evidentiary shortcuts and proxies that managed care supplied. The larger questions of how well competition serves consumer interests may well come to play a pivotal role in the determination of judicial outcomes. Judicial and political disenchantment with managed care became evident in the 1990s. History may well repeat itself.