

# Introduction to Health Care Antitrust Symposium

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The antitrust laws are as sweeping as they are succinct. Read literally, their sanctions against restraints of trade and monopolization will prohibit almost any agreement or consolidation, whether it impairs or enhances competition, in almost every sector of interstate commerce. For more than a century, courts struggled to limit the laws' application to only conduct that threatened competition, and to let the forces of free enterprise, or the mandates of specific regulations, govern all other economic activity. Nowhere are those struggles more evident than in two United States Supreme Court cases that contain one of the most famous quotes in antitrust history, and in the sector that is the subject of this Issue Three of Volume 48 of the *Loyola University Chicago Law Journal*.

At least twice, the Supreme Court called the antitrust laws “the Magna Carta of free enterprise”—the first time in an opinion condemning an economic integration that the trial court had found to be procompetitive, and the second time when refusing to apply the laws against a regulated monopolist.<sup>1</sup> In *United States v. Topco Associates, Inc.*, the Court held that licensing restrictions among smaller grocery stores, which helped them compete against larger chains, were per se illegal.<sup>2</sup> Benefits to interbrand competition were no justification for intrabrand restraints. In the second case, *Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP*, the Court held that antitrust laws do not require monopolists to supply competitors who need the supplies to compete, even if other regulations do impose the duty.<sup>3</sup> If *Topco* represented the sweep of the law, then *Trinko* showed its limits. Both decisions acknowledged that unrestrained antitrust enforcement could impair competition, both recognized that the laws will yield where other regulations apply, but beyond the dissent in *Topco* and a passing

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1. *Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398 (2004); U.S. v. *Topco Associates, Inc.*, 405 U.S. 596 (1972).

2. *Topco*, 405 U.S. 596, 607–08 (1972).

3. 540 U.S. 398, 411–12 (2004).

reference in *Trinko*, neither elaborated on the analysis that distinguishes procompetitive from anticompetitive effects.<sup>4</sup>

The same issues frequently arise in the application of antitrust law to delivery of health care. Significant activity within the sector has been ceded to state and federal regulators,<sup>5</sup> governments pay for more services than any other buyer, and federal legislation recently restructured reimbursement practices to expand health care availability and influence the consumption of medical services. Still, one sixth of the American economy that comprises health care expenditures remains subject to the same antitrust laws that govern other businesses. And the health care industry has been a copious source of antitrust developments—enforcers, practitioners, experts, and judges have all tried to adapt the principles of antitrust to protect competition in the health care sector.

From electronic health records to physician licensing, hospital mergers to drug approvals, the health care industry has many regulated aspects at the federal, state, and local levels, and by private entities at the nongovernmental level. In this saturated regulatory market, antitrust laws and regulation must work together to produce the best results for consumers, payors, the health care industry, and society. Given the state of health care in the United States today, there is no time like the present to emphasize the crucial interplay between health care and competition. In fact, human capital and the economy depend on it.

As chair of the Antitrust Section of the American Bar Association for 2016–17, I therefore asked Professor Spencer Weber Waller and Loyola University Chicago School of Law to join me in putting together a symposium to explore these themes. Our goal was to present, through an interdisciplinary symposium, some of the best minds of academia, practice, medicine, economics, and public policy to examine the current state of health care competition and regulation, and future paths to best serve the public interest. I want to thank Professor Waller, the law school, the Institute for Consumer Antitrust Studies, and the Beazley Institute for Health Law and Policy for serving as cosponsors and for hosting the symposium on September 20, 2016. I also want to thank the *Loyola University Chicago Law Journal* for serving as a cosponsor and devoting this special Symposium Issue to the articles, keynote address, and comments from the symposium.

The articles in this Issue demonstrate that success in health care

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4. *Topco*, 405 U.S. at 613 (Burger, C.J., dissenting), *Verizon Commc'ns Inc. v. Law Offices of Curtis v. Trinko*, 540 U.S. 398, 412 (2004).

5. The business of insurance, for example, is exempt to the extent that it is regulated by state law. McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011–15.

regulation and competition policy is sometimes elusive: concentration is high, entry is difficult, services are costly, and efficiency is questioned. Fortunately, these same articles—individually and collectively—also grapple with whether competition policy, when properly applied, can offer valuable benefits to health care providers, payors, patients, and consumers.

For a sample of the challenges facing health care antitrust, peruse the keynote address of Dr. Zeke Emanuel, who describes the objectives of the Affordable Care Act, assesses its progress to date, and predicts alternative futures of health care finance and delivery. Among his more provocative propositions are his praise for incentives for reducing the quantity of services delivered; his preference for regional or national pricing of services; a call for regulation of hospital pricing; his use of standardization of services as an indicator of efficiency and quality of care; and, most importantly, his advocacy of a change in the basis for physician payments—from fees for services to rewards for outcomes. His observations on consolidation in the health care industry are of special relevance to antitrust analysts. The distinctions he draws between horizontal combinations that increase market share and practice integrations that improve efficiency are the same issues framing enforcement and litigation over mergers in the health care sector. Equally intriguing is his praise of behavioral economics as a guide to improving medical decision making.

Providing additional context to the current state of health care in the United States, Rachel Page, a third-year law student at the Loyola University Chicago School of Law, presents a recent development that highlights recent federal legislation on a site-neutral payment policy and the rules that the Centers for Medicare and Medicaid Services implemented regarding the same.<sup>6</sup> Different rates for the same service are familiar terrain for most antitrust nomads, but Ms. Page's analysis of new rules of government reimbursement highlights the complexities of evaluating the true cost of health care while addressing desired population health outcomes.

For a critical analysis of whether it is even appropriate to evaluate health care through the lens of antitrust and under a standard economic theory, take note of Professor Lawrence Singer's contribution.<sup>7</sup> Professor Singer argues that the current health care market lacks in transparency, and that consumers, by extension, cannot make informed

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6. Rachel Page, *The Shift Toward Site-Neutral Payment Policy in Medicare* 48 LOY. U. CHI. L.J. (forthcoming May 2017).

7. Lawrence Singer, *Health Care is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It.*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

choices. Citing the complex responsibilities of the patient-consumer, Professor Singer suggests that the influence of procompetitive forces may actually cause harm to a patient. Always the optimist, Professor Singer offers a glimmer of hope noting that there “certainly is a place in health care for a consumer focus on cost and quality.”<sup>8</sup>

The struggles of litigators and courts to apply the principles of antitrust to activities in the sector have provoked doubts as to whether it can be done. Analyzing decades of enforcement history, Professor Waller, who convened the symposium that inspired these contributions, asks whether health care developed its own body of antitrust analysis—one that does not apply elsewhere, and which does not work particularly well here. Professor Waller declares:

In short, we have reached a fork in the road, and therefore must confront either returning to the application of traditional antitrust principles in the health care sector or creating a more conscious and well thought out comprehensive scheme of sectoral regulation that clearly lays out when competition rules are secondary to other policy goals.<sup>9</sup>

Prominent health care practitioners, Roxane Busey and Leigh Oliver, disagree with the proposition that competition policy in health care has failed as often, or departed as far from its principles, as Professor Waller contends.<sup>10</sup> Noting many precedents in other industries on which courts have relied to shape health care rulings, the attorneys argue that antitrust is alive and well in the health care sector, notwithstanding the numerous regulations and exemptions the courts must navigate.

Agreeing with Ms. Busey and Ms. Oliver, and taking issue with Professor Waller, Dr. Paul Wong and Dr. Lawrence Wu argue that antitrust enforcement is more likely to improve health care than the regulations:

One should be skeptical that new regulation and regulatory processes can handle the complexity and case-specific nature of competition issues in health care. But the courts are well equipped to do just this, as they are armed with the ability to consider case- and time-specific facts and to apply antitrust law with those facts in mind. The health care industry is not at a fork in the road and it has not lost its way when it comes to antitrust. In fact, applying antitrust in health care is the road that has always been traveled, and with the right antitrust principles in

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8. *Id.*

9. Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

10. Roxane C. Busey, *A View from the Trenches: A Reply to Professor Waller's "How Much Health Care Antitrust Is Really Antitrust?"*, 48 LOY. U. CHI. L.J. (forthcoming May 2017); Leigh Oliver, *It Is All About the Facts: Commentary on the Current State of Antitrust Enforcement in Health Care*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

hand to lead the way, the industry will continue to move forward, not backward.<sup>11</sup>

On some of the narrower issues, the symposium contributors found it easier to agree. Richman et al., for example, suggest that megamergers in the pharmaceutical industry may actually invigorate the marketplace for discovery and that alternative information mechanisms and active financing markets could mitigate and counteract concentration concerns.<sup>12</sup> Dynamic forces are at play in the pharmaceutical industry, and Richman et al.'s analysis of merger and acquisition trends in the pharmaceutical industry leaves us with some surprising, if not thought-provoking, conclusions for competition policy and innovation.

Most encouraging to this reader is the fact that virtually all the contributors find hopeful prospects for the future of antitrust in health care. In addition to Dr. Emanuel's grand vision and Professor Waller's two paths, the article by Professor David Hyman and Professor William Kovacic describes simple changes to the regulation for drug reimbursements that could allow market forces to reduce prices.<sup>13</sup> And Professor William M. Sage and Professor Hyman envision a future with advancing innovation and receding regulation—with antitrust enforcement facilitating the shifts.<sup>14</sup> Their article suggests that declining concentration and new forms practice could emerge—some resembling the changes Dr. Emanuel hopes to see. Likewise, they address some of the concerns Professor Waller and Professor Singer express about the ability of antitrust enforcement to clean the barnacles of bad decisions that may have reduced competition and impeded efficiency without protecting the quality in this sector that is critical to the economy and to every consumer in it.

Each article in this Issue delivers a valuable lesson on antitrust in health care. Together, they present an entire course. Policymakers would do well to peruse these pages. If just some of the ideas presented by the authors here make their way to the marketplace, patients could enjoy better care at lower costs. In other words, antitrust can heal the ailments in this health care market, just as it has in many others.

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11. Paul Wong & Lawrence Wu, *Health Care Antitrust: Are Courts Adapting to a Complex and Dynamic Industry or Are They Making Exceptions?*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

12. Barak Richman et al., *Pharmaceutical M&A Activity: Effects on Prices, Innovation, and Competition*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

13. David A. Hyman & William E. Kovacic, *Health Care Competition Law in the Shadow of State Action: Minimizing MACs*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

14. William M. Sage & David A. Hyman, *Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).