The Massachusetts AG Report: Implications for Competition Policy and PPACA Implementation

Thomas (Tim) Greaney
Chester A. Myers Professor and
Director, Center for Health Law Studies
Saint Louis University School of Law
Provider Markets: Worst of Both Worlds

- **Concentration and Fragmentation**
  - Concentrated hospital & specialty physician practice markets
    - High market shares common across the country
    - Entry is limited by CON, curbs on specialty hospitals, contracting practices of incumbents,
  - Fragmented delivery system
    - Primary care in small practices
    - “Silo effect”: Lack of coordination between physicians and between physicians and hospitals

- **Consequence:** Higher prices/premiums
  - RWJ Synthesis study; MA AGO; Berenson & Ginsberg (*Health Affairs* 2010)
Health Insurance Markets

- Market Concentration (*take with 2 mg. of salt*):
  - 39 states: two firms control at least 50% of the market,
  - 9 states: a single firm controls at least 75% of the market
- Evidence that Health Plans may exercise market power
- New Entry not likely in markets with dominant insurers
  - DOJ Study, described by AAG Varney (June 2010):
    - “New entrants or niche players are more likely to receive provider discounts comparable to their competitors’ in less concentrated markets than they are in markets dominated by one or two plans. This is because no one plan provides such a large number of enrollees that it can demand, and likely receive, disproportionately larger provider discounts than other incumbents or possible entrant.”
Antitrust Law: Only Marginal Help

- Lax merger enforcement facilitated concentration
  - Dubious court decisions
  - Mergers “below the radar screen” (esp. physicians)
    - Impractical to break up consummated mergers
    - “No merger not worth trying”
- NO effective remedy to deconcentrate markets
- Antitrust law prohibits misuse of monopoly power but does not challenge exercise of lawfully acquired power
  - Monopoly pricing, refusals to deal: *legal*
Dominant Insurer Meets Dominant Hospital (Bilateral Monopoly)

- Economic account of competitive outcome: Uncertain
- Anticompetitive scenario: Mutual Accommodation
  - Partners/ Blue Cross
  - Allegations in exclusion cases
    - Little Rock Cardiology
    - West Penn Allegheny v. UPMC
- Health plan Most Favored Nations clauses
  - Ambiguous precedent: Ocean State; Delta Dental cases
- New theory: Leverage of regional hosp. systems’ “threat value”
- Other anticompetitive actions by dominant hospitals
  - Bundling: Cascade v. Peace Health (9th Cir. 2008)
    - Dominant hospital w/ tertiary care offers bundled discount for tertiary, secondary and primary care
    - Only rival (no tertiary services) can’t match
Little Rock Cardiology v. Baptist Health (8th Cir. 2009)

LRCC
- Cardiology group practicing at Baptist Hospital
- Owns Arkansas Heart Hosp. (specialty hosp)

Baptist Health
- Dominant “must have” hospital

Arkansas BCBS: “Dominant” insurer

Pl’s claim; “Reciprocal exclusive dealing” between BCBS & Baptist to secure their dominant positions
- BCBS drops LRCC from PPO; Baptist exclusive w/BCBS
Much of PPACA is devoted to making competition work:

- Mitigate market failure (information, agency, insurance)
- Exchanges, subsidies research, insurance market regulation
- Delivery system reform ACOs. Medical homes
ACOs: Competition Conundrums

- Potential to exacerbate provider market power
- Unanswered question: Which paradigm?
  - Market competition or rate regulation?
- Role of market issues in HHS Regulations
  - Input from FTC/DOJ
  - PPACA: “Preference” for ACOs with private market links
  - Payment models: Shared savings v. Partial capitation
  - “All payer” ACOs?
    - Standardized protocols for providers
- Antitrust Issues
  - Ease/Clarify standards to permit loose (clinically integrated) physician networks
  - Policing the “PPACA Merger Wave”