

**FOREWORD:
COMPETITION'S ACHILLES HEEL**

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The Achilles heel of competition is concentration. Markets dominated by a single or a few buyers or sellers protected by barriers to entry do not perform efficiently. In the health care sector, market imperfections and extensive regulation further complicate matters, as conventional economic analyses need to account for their distortive effects.¹ Often misunderstood as the guarantor of competitive market conditions, antitrust law has only a constrained role to play in dealing with the problem of what I refer to as “extant market power.”² That is, where mergers or organic growth has resulted in highly concentrated market structures (e.g., three or fewer rivals)—as is the case in many health provider and payor markets—antitrust law is largely tolerant of high prices unless those in dominant positions collude or abuse their market position by exclusion or other improper means. Moreover, economic analyses indicate that some important accretions in market power occur in circumstances that have largely escaped antitrust challenge, e.g., vertical cross-market combinations, have the potential to cause significant harm to consumers.³

The resulting challenge for health care competition policy is finding ways to curb the exercise of extant market power and, where possible, to expand the capacity of antitrust or regulatory measures that inhibit the ability to obtain dominance. There are, to be sure, reasons to question the advisability of some of the ad hoc measures undertaken by antitrust enforcers and state legislatures to address provider market power. For example, some state attorneys general have negotiated so-called “conduct remedies” that allow mergers by dominant

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1. See MARTIN GAYNOR ET AL., THE BROOKINGS INST., MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE, ACTIONABLE POLICY PROPOSALS FOR THE EXECUTIVE BRANCH, CONGRESS, AND THE STATES 1–2 (Apr. 2017), <https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf>; Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 857–58 (2004).

2. Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1565 (2017).

3. Glenn A. Melnick & Katya Fonkych, *Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems*, 53 INQUIRY 1, 5 (2016). See generally Jaime S. King & Erin C. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

hospitals to go forward while imposing certain restrictions on the behavior of the merged entity. These remedial provisions have included restrictions on raising prices to commercial insurers, promises that the merged entity will negotiate in “good faith,” and provisions that require the merging parties to employ “separate and independent” negotiating teams when contracting with payors.⁴ These home remedies are in my view inherently flawed. Besides the difficulty of crafting *ex ante* solutions, they are difficult for government agencies to implement and monitor, and do not address entrenched market power; moreover, there are issues of institutional competence in investing regulatory supervision over a complex and rapidly changing business environment in courts, as one state court acknowledged in refusing to accept such a decree.⁵

Another deeply flawed approach adopted in several states is the establishment of regulatory agencies that issue certificates of public advantage (COPAs) that immunize anti-competitive mergers while subjecting the merged hospital to regulatory controls on price and a variety of other matters. The standards for approving mergers under these statutes are numerous, conflicting, and not subject to empirical analysis or measurement and hence subject to risks of capture by the regulated entity.⁶ Moreover, the nation’s experience with certificate of need and rate regulation of hospital charges counsels against adopting open-ended rate regulation in this manner. Application of state COPA statutes have caused the Federal Trade Commission to abandon antitrust challenges to mergers to near monopoly in West Virginia⁷ and the Tennessee-Virginia border area.⁸

Some states are turning to capping provider rates using supervisory regulation of commercial insurance. Regulatory approaches range from open-ended regulation of insurance rates designed to intensify payors’ resistance to provider price increases to more targeted designs that cap the prices of dominant

4. Greaney, *supra* note 2, at 1566.

5. See *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2, 2015 WL 500995, at *1 (Mass. Super. Ct. Jan. 30, 2015) (“This Court is ill-equipped to keep abreast of . . . changes [in health care pricing] as they unfold . . . [T]here is reason to doubt that this Court has the technical competence or resources required to resolve the disputes that are certain to arise under this consent decree . . .”).

6. For example, the West Virginia COPA statute lists nine goals, nine benefits, and four disadvantages to be considered by the regulatory board. See W. VA. CODE § 16-29B-28 (2017); Greaney, *supra* note 2, at 1567.

7. Press Release, Fed. Trade Comm’n, FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary’s Medical Center (July 6, 2016), <https://www.ftc.gov/news-events/press-releases/2016/07/ftc-dismisses-complaint-challenging-merger-cabell-huntington> (last visited Feb. 28, 2018).

8. See Alex Kacik, *Mountain States, Wellmont Skirt Federal Regulation and Score State Merger Approval*, MOD. HEALTHCARE (Nov. 3, 2017), <http://www.modernhealthcare.com/article/20171103/NEWS/171109954> (last visited Feb. 28, 2018).

providers.⁹ Other states are exploring more thoroughgoing regulation including single-payer options.¹⁰ This newfound enthusiasm for rate regulation, notably visible even in some red states, underscores the fact that market power has become a central issue in health law and policy.

This symposium brings together an impressive collection of individuals from academic, public policy, and legal practice sectors to examine the issue of concentration in health care.¹¹ The articles include several taking a close look at the promise and gaps in antitrust enforcement. Anne Marie Helm provides a thorough overview of the hurdles faced by private litigants in bringing antitrust lawsuits.¹² Jaime King and Erin Fuse Brown dissect an important phenomenon yet to be addressed by antitrust enforcement, the creation of “system” market power by cross-market mergers.¹³ A second theme of the symposium is the interplay of regulation and competition policy in health care. Emilio Varanini offers insights as to the role of state legislation, regulation, and law enforcement in buttressing the effectiveness of market competition in serving the public good.¹⁴ Zack Buck takes a close look at the rapid emergence of managed care in Medicaid, analyzing the bidding processes used to inject competition into the program and the regulation and litigation encountered in several states that employed competitive bidding.¹⁵ Finally, Robert Berenson delves into the regulatory structures governing traditional Medicare and Medicare Advantage,¹⁶ an issue that was front and center in the government’s successful challenge to the merger of Aetna and Humana.¹⁷ His analysis reveals the central role regulation plays in shaping competition in Medicare Advantage and raises important issues regarding the advisability of converting Medicare to a premium support system.

9. See Greaney, *supra* note 2, at 1568–69.

10. See Melanie Mason, *The Debate Over Single-Payer Healthcare in California Isn't Going Away. Here's Why*, L.A. TIMES (Aug. 27, 2017), <http://www.latimes.com/politics/la-pol-ca-single-payer-politics-20170827-story.html> (last visited Feb. 28, 2018).

11. Video Recording: Coping with Health Care Market Concentration, ST. LOUIS U. CTR. FOR HEALTH L. STUD. (Apr. 7, 2017), <http://law.slu.edu/HLsymposium2017>.

12. Anne Marie Helm, *Optimizing Private Antitrust Enforcement in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

13. Jaime S. King & Erin C. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

14. Emilio Varanini, *Competition as Policy Reform: The Use of Vigorous Antitrust Enforcement, Market-Governance Rules, and Incentives in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

15. Isaac D. Buck, *Managing Medicaid*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

16. Robert A. Berenson, *When is Competition Not Competition: The Curious Case of Medicare Advantage*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y ORIG-PG, PINCITE (2017).

17. See *United States v. Aetna Inc.*, 240 F. Supp. 3d 1 (D.D.C. 2017).

This symposium marks the end of my twenty-nine year career at Saint Louis University. In that time, I have had the opportunity to interact with some of the leading scholars, practitioners, and policy experts in some twenty-nine health law symposia. Further it has been both a pleasure and an honor to work with my wonderful faculty colleagues and outstanding students in building and maintaining the nation's leading health law center. I am grateful to all for their friendship and support.