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Too Few Thimbles on the Monopoly Board: How Concentration in Provider Markets Have Driven Healthcare Costs

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INTRODUCTION

Debates surrounding the American healthcare system often try to address the coinciding issues of cost and access to the consumer. This can be attributed to the fact that the United States spends more than any other economically developed country on health care, both as a percentage of GDP and per capita, while having almost 29 million uninsured nonelderly citizens.¹ Moreover, the United States spends more on health care than on any other sector of the economy, including defense, transportation, education, or housing.² Although more spending is not facially problematic, our uninsured rate and adequate health outcomes prompt an important debate about why this country spends so much without better results. Unfortunately, the system functions as a complex web and has resulted in hamstrung consumers and a concentrated market of suppliers and third-party payers.

This is concerning for reasons other than the obvious fact that affordable health care is important to physical and psychological well-being of the country's citizens. Our inefficient healthcare system has affected the general economic health of the nation. U.S. health care spending was \$3.8 trillion in 2019, amounting to almost 18 percent of the nation's gross domestic product.³ The more money that is tied up in the industry's army of middlemen, the less there is available to be invested in economic growth for the public generally. Moreover, the financial health and stability of the Medicare Trust Fund is dire, given that it is projected to be depleted in 2026.⁴ Additionally, Social Security Trust Funds for old-age benefits and disability

¹ Barry R. Furrow, Et al., *Health Law: Cases, Materials and Problems* (8th edn, West Academic 2018).

² *Id.*

³ Centers for Medicare & Medicaid Services, National Health Expenditure Data, *Historical*, (Dec. 2020), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>

⁴ Robert Pear, *Medicare's Trust Fund Is Set to Run Out in 8 Years*. *Social Security*, 16., The New York Times (Jun. 5, 2018), <https://www.nytimes.com/2018/06/05/us/politics/medicare-social-security-finances.html>

insurance, taken together, could be depleted in 2034.⁵ Therefore, the financial viability of these safety net programs carries obvious macroeconomic importance.

Understanding the origins of these high costs has been one of consistent and rigorous study. This is because that generally, when patients are forced to pay more for health care, they are less likely to access treatment.⁶ This conundrum drives a reluctance of those patients to consume preventative treatments, which in turn enhances the seriousness of their health episodes.⁷ As health episodes become more dire, costs increase further because of the intensity of services provided.⁸ It is also important to define “costs” as they pertain to patients and providers. Costs to patients typically include premiums paid to insurers and out of pocket expenses paid to providers. Costs to providers are typically related to service and product operating expenses.

According to a study that analyzed the five most prevalent cost drivers for patients—population growth, population aging, disease prevalence or incidence, service utilization, and service price and intensity—increases in health care prices have been more strongly associated with overall increases in health care spending than any other suggested factor.⁹ The study’s definition of “service price and intensity” depended upon the type of health care service provided. For example, for ambulatory, emergency department, and dental care, “service price and intensity” was defined as the mean spending per visit.¹⁰ For inpatient and nursing facility care, “service price and intensity” was the mean spending per bed-day.¹¹ Lastly, for retail

⁵ *Id.*

⁶ Sara Heath, *How Out-of-Pocket Costs Affect Patient Healthcare Access*, Patient Engagement, (Jan. 11, 2017), <https://patientengagementhit.com/news/how-out-of-pocket-costs-affect-patient-healthcare-access> (“Research has shown a relationship between increasing patient cost burden and health service utilization, suggesting that when patients pay more for their healthcare, they are less likely to access treatment.”).

⁷ *Id.*

⁸ *Id.*

⁹ Joseph Dielman, Et al., *Factors Associated with Increases in US Health Care Spending, 1996-2013*, (Nov. 7, 2017), <https://jamanetwork.com/journals/jama/fullarticle/2661579>

¹⁰ *Id.*

¹¹ *Id.*

pharmaceuticals, “service price and intensity” was the mean spending per purchased prescription.¹² The study, which analyzed US health care spending from 1996 to 2013, discovered that “price and intensity” alone accounted for more than 50% of the spending increase.¹³ Furthermore, the study concluded that the increase in prices were greatest in inpatient care.¹⁴ Therefore, although there are other factors that contribute to high spending, to improve the prevailing issues of cost and access to healthcare in the United States, policymakers, providers, and insurers must curtail prices of services delivered to patients. To curtail the prices of health care services, it is important to depict the structures of the system that are to blame for increases in prices. This paper argues in part that what has been called “the double-edged sword” of care integration and the market consolidation it causes ought to be considered the reason.¹⁵

Since the 1990s, both market forces and policy actions have resulted in enhanced care coordination via vertical care integration. In health care, vertical integration refers to the consolidation of providers of different elements of health care services, such as hospitals and physicians, which collectively supply those elements of the health care service to the patient.¹⁶ The presuppositions of vertical care integration are that it helps eliminate waste, encourage shared resources, and reduce overhead expenses.¹⁷ This in turn will reduce general health care costs and improve the experience for the consumer. The Patient Protection and Affordable Care Act of 2010 (ACA) accelerated this trend, and pursued concepts that incentivized greater care coordination.¹⁸

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Erin C. Fuse Brown & Jaime S. King, (2016) "*The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*," *Indiana Law Journal*: Vol. 92 : Iss. 1 , Article 2. 56, 60 (2016)

¹⁶ *Id.* at 62.

¹⁷ *Id.* at 57.

¹⁸ 42 C.F.R. § 425.100 (2010)

Unfortunately, these market trends and policy initiatives have realized unforeseen consequences for health care prices in America. Specifically, the heightened desire to pursue care coordination has coincided with a marketplace of providers and insurers that has concentrated in recent years. According to an aggregation of Kaufman Hall data, from 2000-2009, there was an average of sixty hospital and health system mergers and acquisitions per year.¹⁹ From 2010-2019, that number increased to ninety-six average hospital and health system mergers per year.²⁰ This report also highlighted the fact that mergers and acquisitions will continue to trend upward.²¹ Moreover, this trend in consolidation has also shifted from larger systems acquiring smaller organizations to larger systems merging. The average size of seller by annual revenue was below 2018's record high of \$409 million but remained above historical averages at \$278 million.²² The average seller size by revenue has trended upward since 2009, from almost \$150mm to over \$350mm in 2018.²³ Although provider network executives have predicted that these consolidation trends would lead to better value for consumers, that value has yet to be realized. Unfortunately, as market concentration has proliferated, as has the buying power of provider networks, which has resulted in increased health care prices.²⁴

This paper will further analyze these concentration trends and provide insight into proposals that seek to combat the double-edged sword of fragmentation and competition. The

¹⁹ Revcycle Intelligence, *How Hospital Merger and Acquisition Activity is Changing Healthcare*, (Jul., 18, 2018), <https://revcycleintelligence.com/features/how-hospital-merger-and-acquisition-activity-is-changing-healthcare>

²⁰ Kaufman, Hall & Associates, LLC, *2019 M&A in Review: In Pursuit of the New Bases of Competition* (2020), https://www.kaufmanhall.com/sites/default/files/documents/2020-01/2019_mergers_and_acquisitions_report_kaufmanhall.pdf, at 5.

²¹ *Id.* at 13 (“Kaufman Hall expects many of the trends from 2019 to carry forward into 2020, including: Competition to control healthcare’s front door, new combinations across healthcare verticals, continued growth of regional health systems, and an emphasis on increased reach within existing markets.”).

²² *Id.* at 5

²³ *Id.* at 7

²⁴ Eric T. Roberts, Michael E. Chernew, and J. Michael McWilliams, *Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices*, (Jan. 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0479>

paper will analyze some of the trends in consolidation, as well as a dive into the lack on anti-trust litigation that has failed to counteract it. The paper will argue in favor of policy pursuits that promote greater consumerism within the system, such as the Direct Primary Care model. These concepts can help manage prices, over-utilization, and expand greater access to American citizens. Additionally, this paper will also address counter arguments and proposals, and provide an argument as to why monopsony such as Medicare-for-All is an undesirable initiative for the U.S. to pursue.

Part I will further review policy trends of the past few decades that brought us to this conundrum of market consolidation and high prices. Part II will depict and analyze Senator Bernie Sanders Medicare for All proposal. It will also review President Biden's proposed reforms to the healthcare system. Part III will summarize and detail Avik Roy and Dr. Ryan Neuhofel's patient-centered proposals to fix health care.

I. Understanding High Prices in Health Care and Their Prevailing Causes

As detailed above, prices of services provided has been the main driver of health care costs in America. This was detailed in a report that the Organization for Economic Co-operation and Development (OECD) conducted in 2014. According to the OECD's report, among its developed member countries, the median hospital stay cost \$10,530 and lasted almost eight days in 2014.²⁵ In the United States, the average hospital stay cost \$21,063, despite lasting only six days.²⁶ Therefore, the average daily cost of a hospital stay in the U.S. was more than 2.5 times that of the OECD average of developed nations.²⁷

²⁵ Dana Sarnak, *Multinational Comparisons of Health Systems Data, 2016*, The Commonwealth Fund (2016), https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_chartbook_2016_att_f_sarnak2016_oecd_data_chartpack_final_pdf.pdf.

²⁶ *Id.*

²⁷ *Id.*

Furthermore, the differences in prices vary depending on whether the payer is a public or private insurance plan. According to a 2015 study that researchers at the U.S. Agency for Healthcare Research and Quality conducted, hospitals were charging private insurers 106 percent of Medicare rates in 1996, but 175 percent of Medicare rates in 2012.²⁸ Moreover, according to a 2019 RAND Corporation study, test hospitals were 241 percent of Medicare prices in 2017.²⁹ This evidence implies that there are irregularities in the commercial payer market that are causing these high prices.

a. How Health Care Prices are Negotiated and its Effect on Consumers

As stated above, the definition of health care “costs” often varies depending on whether they are in reference to the patient or the provider. Provider costs are typically related to service and product operating expenses, general overhead, and labor.³⁰ As in other industries, prices are set to cover these costs, so the excess realized from services charged is what makes up a large portion of the provider’s revenue. Prices of health care services are determined during negotiations between providers and insurers.³¹ Because each price negotiation is individualized, what insurers agree to pay providers vary.³² Due to the historical practice of private negotiations, price agreements between providers and insurers are not transparent.³³ Typically, then, neither providers or insurers can compare the market rate of health care services that their competitors are charging and paying.³⁴ Most importantly, consumers (and often their employers) are unable

²⁸ Thomas M. Selden, Et al., *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, Health Affairs (Dec. 2015), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0706>

²⁹ Chapin White and Christopher Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely*, RAND Corporation (2019), https://www.rand.org/pubs/research_reports/RR3033.html.

³⁰ Barry R. Furrow, Et al., *Health Law: Cases, Materials and Problems* (8th edn, West Academic 2018).

³¹ See Roberts, Chernew, McWilliams, *supra* note 24.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

to ascertain what certain health care procedures will cost under the insurance plan that they have invested in.³⁵

Unfortunately for consumers, these private negotiations have led to egregious examples of anticompetitive practices that have left consumers worse off. For example, in 2018, the *Wall Street Journal* obtained hidden contracts between insurers and hospitals revealing that certain contracts prohibited insurers from allowing patients to visit less-expensive or higher-quality health care providers.³⁶ These “anti-steering clauses” essentially helped hospital networks guarantee a certain amount of business through their contract with the insurer.³⁷ The *Journal’s* findings also revealed that some networks prevented insurers from excluding some of the system’s hospitals from the insurer’s networks.³⁸ Moreover, certain contract provisions allowed a hospital operator to block information from online shopping tools that insurers offer to beneficiaries to show a hospital’s prices.³⁹ Other anti-consumer provisions included in the *Journal’s* findings included hospital charges called “facility fees.” These fees “are supposed to cover the extra costs associated with care given in a hospital setting, including regulatory and safety standards that apply to hospitals.”⁴⁰

Although one may assume that the manner of negotiations between providers and insurers would have a net negative effect on competing insurers and providers, that is not exactly what has happened. As providers have been incentivized through market forces and government policy to consolidate, insurers have felt the need to increase their bargaining power as well.⁴¹

³⁵ *Id.*

³⁶ Anne Wilde Mathews, *Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition*, *The Wall Street Journal* (Sep. 18, 2018), https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963?mod=article_inline

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ See Roberts, Chernew, and McWilliams, *supra* note 24.

Economic science would suggest that this could allow those insurers to negotiate lower prices, due to an expanded beneficiary pool. But, as both markets have centralized, there is concern that the relationship between the parties has become one of negotiating shared interests, instead of competitive prices for consumers.⁴² This creates a scenario where providers and insurers are negotiating for their sustained profitability, which in turn ignores beneficiaries. The ACA's medical-loss ratio provision, which requires insurers to spend approximately 80 percent of premium dollars on medical care and health care quality improvement, took aim at this issue.⁴³ A 2017 study that examined differences in negotiated rates for office-based physician services, based on differences in the ability to bargain over prices, provides insights into this matter.⁴⁴

The study found that differences in providers' and insurers' bargaining power are a distinct contributor to variation in commercial health care prices.⁴⁵ "We estimated that—within the same provider groups—insurers with market shares of 15 percent or more ... negotiated prices for office visits that were 21 percent lower than prices negotiated by insurers with shares of less than 5 percent."⁴⁶ Additionally, analyses of provider network market share suggested that insurers require greater market shares to negotiate lower prices from large provider groups than they do when negotiating with smaller provider groups: "Office visit prices for small practices were \$88, \$72, and \$70, for insurers with market shares of <5 percent, ≥5 to <15 percent, and ≥15 percent, respectively, whereas prices for large provider groups were \$97, \$86, and \$76, exhibiting a continued decrease across higher insurer-market-share categories."⁴⁷

⁴² Thomas L. Greaney, *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition*, Prepared Statement Before the Committee on the Judiciary United States House of Representatives, Subcommittee on Regulatory Reform, Commercial and Antitrust Law (Sep. 10, 2015), <https://republicans-judiciary.house.gov/wp-content/uploads/2016/02/Greaney-Testimony.pdf>.

⁴³ Social Security Act, 42 U.S.C. § 1395w-27(e)(4) (2010)

⁴⁴ See Roberts, Chernen, and McWilliams, *supra* note 24.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

Although insurers with large market shares can negotiate lower prices, the authors of the study suggest that greater consolidation of the commercial health insurance marketplace is not necessarily the solution.⁴⁸ The study suggests, as this paper will argue, that enhanced antitrust enforcement into heavily concentrated providers and insurers is a necessary remedy. Most notably, the authors are uncertain as to whether customers of larger insurers are realizing the benefits of these insurers' ability to negotiate prices.⁴⁹ According to the authors of the study, more time, data, and research are needed to properly ascertain the effectiveness of the ACA's medical-loss ratio provision.⁵⁰

b. Integration in Name, Consolidation in Practice

Before the 1990s, the U.S. health care and insurance system had pursued policies and market concepts of what is referred to as horizontal integration. Horizontal integration is the concept of organizations acquiring or integrating with other organizations that provide the same or similar services such as multispecialty practice organizations.⁵¹ Since the 1990s, in attempts to lessen the fragmentation effects that horizontal integration had on the system, U.S. providers moved towards a system that promoted vertical integration.⁵² As described above, in practice, vertical integration is when organizations acquire or integrate with other organizations offering different levels of care, services, or functions such as hospital ownership of physician practices.⁵³

⁴⁸ *Id.* (“Insurer consolidation could prompt additional provider mergers, whose countervailing effects on price negotiations might not ultimately lead to a net decline in prices.”)

⁴⁹ *Id.* (“It is not clear that the lower prices negotiated by large insurers are shared with consumers in the form of lower premiums or more generous benefits.”)

⁵⁰ *Id.* (“Since much of the research on insurance market structure and premiums is based on data predating the ACA, and in light of the current political uncertainty surrounding the ACA, it is not clear whether this provision will ultimately be effective in ensuring that insurers' savings from lower negotiated prices are passed on to consumers.”)

⁵¹ Jessica Heeringa, et al., *Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organizational Structures* (Jan. 20, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978994/#:~:text=Between%20the%201980s%20and%20mid,a%20multihospital%20systems%20or%20multispecialty>

⁵² See Brown & King, *supra* note 15, at 70-71.

⁵³ See Brown & King, *supra* note 15, at 61.

An example of vertical integration would be a hospital buying a physician group or a health system that forms a drug company. Streamlining providers via vertical integration can help eliminate wasteful or repetitive services, encourage shared resources, and reduce overhead expenses.⁵⁴ For example, consolidated hospital and physician efforts in the supply chain can align financial incentives between hospitals and referring physicians, reduce over-utilization, and provide centralized administrative services.⁵⁵ Additionally, vertical integration of providers or insurers into integrated delivery systems may reduce the costs of complex negotiations between these parties.⁵⁶

Unfortunately, initial concepts of vertical integration failed to foresee and mitigate the effects of over-utilization in the system.⁵⁷ This issue of over-utilization, particularly in expensive regions on the country, became apparent to policy makers during the Obama Administration.⁵⁸ In 2009, physician and journalist Atul Gawande discovered that in spending regions of the country where health care spending was unusually high, the issue was not poorer health populations.⁵⁹ He found that physicians and specialists were prescribing procedures that were unnecessary and economically inefficient.⁶⁰ Gawande's research provided a detailed synopsis as to how providers can exploit the fee-for-service payment model (FFS) to their benefit.⁶¹ At the time, Peter Orszag, President Obama's budget director, cited Gawande's research and estimated that "the federal government could have eliminated nearly 30% of Medicare spending without sacrificing quality of outcomes if higher-spending regions mirrored utilization patterns of lower-spending

⁵⁴ See Brown & King, *supra* note 15, at 61.

⁵⁵ See Brown & King, *supra* note 15, at 62.

⁵⁶ See Brown & King, *supra* note 15, at 62.

⁵⁷ Atul Gawande, *The Cost Conundrum*, *The New Yorker* (Jun. 1, 2009), <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum> [<https://perma.cc/5JHY-4WV4>].

⁵⁸ See Brown & King, *supra* note 15, at 57.

⁵⁹ See Gawande, *supra* note 57.

⁶⁰ *Id.*

⁶¹ *Id.*

regions.”⁶² This research led several leading health economists to argue that to decrease costs, the U.S. health care system needed to reform its payment and delivery systems to disincentivize and reduce overutilization, and to instead reward coordination, quality, and efficiency.⁶³ This resulted in ACA provisions such as the Medicare Shared Savings Program (MSSP), the Hospital Value-Based Purchasing Program, and the National Pilot Program on Bundling.⁶⁴ Specifically, the MSSP attempted to reform the Center for Medicare & Medicaid Services (CMS) payment system away from one that incentivized volume care to quality care.⁶⁵ The program has encouraged providers to formulate Accountable Care Organizations (ACOs), which were proposed to promote care coordination to reduce unnecessary medical care and improve health outcomes, while reducing utilization of critical care services.⁶⁶ Although the verbiage of the MSSP incentivizes providers to formulate ACOs for Medicare beneficiaries, the intent was that private insurers would pursue the concept as well.⁶⁷

ACOs are provider-based networks that consist of primary care physicians, hospitals, specialists, nursing homes, and other health care facilities that utilize data analytics and community management strategies to achieve cost efficiency and care quality.⁶⁸ Under the MSSP, CMS rewards successful providers in ACOs a portion of the savings they achieve for their payers for balancing spending and quality.⁶⁹ This complements the traditional fee-for-

⁶² *Id.*; see also Brown & King, *supra* note 15, at 57.

⁶³ See Brown & King, *supra* note 15, at 58.; see also Erin C. Fuse Brown, *The Blind Spot in the Patient Protection and Affordable Care Act's Cost-Control Policies*, 163 ANNALS INTERNAL MED. 871 (2015).

⁶⁴ See Brown & King, *supra* note 15, at 63.

⁶⁵ See § 425.100(b), *supra* note 18.

⁶⁶ *Id.*

⁶⁷ See Brown & King, *supra* note 15, at 63.

⁶⁸ Centers for Medicare & Medicaid Services, *Accountable Care Organizations* (Mar. 4, 2021), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO>.

⁶⁹ See § 425.100(b), *supra* note 18.

service model.⁷⁰ In short, ACOs reward value instead of volume, which is meant to address the issue of over-utilization.

Since the passage of the ACA, the growth of ACOs has been steady, with more than 100 ACOs established nationwide at the end of 2011, to almost 1,000 by Q2 2019.⁷¹ From the end of Q2 2018 to the end of Q2 2019, three million people have been added to those who ACOs cover.⁷² At the end of Q2 2019, private insurers covered about 60 percent of ACO beneficiaries, while Medicare contracts covered approximately 30 percent and Medicaid covered 10 percent.⁷³ By the end of Q2 2019, there were 1,588 existing public and private ACO contracts, covering almost 44 million Americans.⁷⁴ At the end of Q2 2019, ACOs cover less than five percent of the population in only six states.⁷⁵

As stated previously, because of the misaligned incentives of the traditional FSS model, a distinctive characteristic of both public and private ACOs is their assumption of greater responsibility and financial risk for performance. Payment contracts are formulated in a way to bind ACOs with upside risks, downside risks, or both.⁷⁶ During negotiations between networks and payers, the thresholds for rewards and risk are set.⁷⁷ Downside risk models typically include the opportunity to accrue higher rates of shared savings.⁷⁸ This makes it more attractive for

⁷⁰ Jesse Migneault, *Understanding the Basics of Accountable Care Organizations*, HealthpayerIntelligence (May 23, 2017), <https://healthpayerintelligence.com/news/understanding-the-basics-of-accountable-care-organizations>, (“The fee-for-service model pays providers for each medically justifiable service they deliver, regardless of whether the service actively contributes to a better health outcome.”).

⁷¹ David Muhlestein, et al., *Spread of ACOs And Value-Based Payment Models In 2019: Gauging the Impact of Pathways to Success*, Health Affairs (Oct. 21, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191020.962600/full/>.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ See Migneault, *supra* note 70.

⁷⁷ *Id.* (“While upside risk ACOs are not responsible to pay back any financial losses if they exceed the agreed-upon spending rates, ACOs participating in a downside risk arrangement will be asked to pay back part of the excess spending they incur.”).

⁷⁸ *Id.*

experienced providers to take on the additional financial risk and greater quality care responsibility.

Although value-based care agreements can vary on a case-by-case basis, the American Academy of Actuaries analyzed the five general payment structures of ACOs in a 2012 report. The first, the “one-sided” shared-savings agreement, is an upside risk contract in which providers are eligible to receive a portion of savings if they meet quality of care standards while providing care at lower-than-projected costs.⁷⁹ The second, the “two-sided” shared-savings model, is one of dual sided risk, in which ACOs still would receive payment primarily on an FFS basis and would be eligible to receive a portion of the savings. They also would be at risk, however, for a portion of spending over the designated target.⁸⁰ Next, the bundled/episode payment arrangement, is one in which provider organizations receive a lump sum payment for all the services a patient requires for an entire episode of care.⁸¹ Here, the ACO and its providers take on the downside risk pertaining to complications during the episode of care.⁸² Fourth, the partial capitation model, is an agreement in which providers receive a fixed dollar payment for specific services that patients may receive in a given time period.⁸³ In partial capitation, the ACO is at risk for some of the services and care provided to patients.⁸⁴ For example, the ACO may be at risk for hospital care but not physician services. Lastly, global payments, which incorporates a high-end of risk for the ACO, pays the network agreed upon monthly or annual payments regardless of services

⁷⁹ Mary Downs, et al., *An Actuarial Perspective on Accountable Care Organizations*, Academy of Actuaries (Dec. 2012), https://www.actuary.org/sites/default/files/files/ACO_IB_UPDATE_Final_121912.pdf.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

given or costs realized.⁸⁵ The ACO bears the risk that payments received are insufficient to cover the costs of the services it provides.⁸⁶

Unfortunately, although these payment structures have attempted to address the fleeting inefficiencies of traditional FFS, they have become another contributor to the market concentration problem. Because these payment models cause providers to endure heightened risk, they have added a consolidation incentive to improve profit margins.⁸⁷ The trend will likely continue, as the proportion of ACOs taking on any downside risk is generally increasing across all ACO types and sizes.⁸⁸ Moreover, 32 percent of physician led ACOs are participating in downside risk contracts, in comparison to 27 percent of hospital led ACOs.⁸⁹ This is evidence that these contracts are becoming more accepted, due to the concerns that physician groups would be reluctant due to smaller financial reserves than hospital networks.⁹⁰ This also helps explain why larger ACOs are more likely to participate in downside risk contracts than smaller ACOs.⁹¹ If smaller ACOs are to transition to downside risk contracts, it is likely that they will need greater incentives, or merge with existing networks.⁹²

c. Antitrust Enforcement has Proven to be Anti-Trustworthy

As market concentration has set root in the American healthcare industry, it is important to analyze the roll that the Department of Justice (DOJ), the Federal Trade Commission (FTC), and states have (or have not) taken to address the issue. These government functionaries can act against predatory pricing, mergers that are anti-competition, bid manipulation, and other

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ See Muhlestein, et al., *supra* note 71.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.* (“Smaller ACOs are those with less than 10,000 beneficiaries.”)

⁹² *Id.*

monopolistic behavior that hurts consumers and the healthcare system writ large. Unfortunately, according to antitrust experts, these law enforcement arms have pulled back from using these powers in recent years, which has helped enable the centralization of the U.S. healthcare system. Antitrust law expert Thomas Greaney has described antitrust enforcement in healthcare as a metaphorical absentee father.⁹³ To understand the failures of antitrust enforcement in healthcare, it is important to understand laws that govern the issue and its related history in court.

There are a few broadly written laws that government can apply to introduce antitrust challenges to health care transactions and activity. Although these laws are applicable to most industries, they typically address the following types of antitrust violations related to healthcare industry transactions.⁹⁴

Section 1 of the Sherman Act prohibits agreements that “restrain trade or commerce.”⁹⁵ According to antitrust law expert Robert Leibenluft, the act of conspiring or contracting to create prima facie price-fixing mechanisms or market division is illegal.⁹⁶ According to Leibenluft, these acts are illegal “even without evidence that the parties to the agreement have market power or that the agreements adversely affect competition.”⁹⁷ Additionally, section 1 of the Sherman Act does not permit defenses that the contract provisions at issue create efficiencies that could counteract adverse competitive effects.⁹⁸ However, according to Leibenluft, it is much more

⁹³ Thomas Greaney, *Competition Policy after Health Care Reform: Mending Holes in Antitrust Law’s Protective Net*, Duke University Press, Aug. 1, 2015, at 897. (“unchecked consolidation over the past fifteen years resulted in markets with dominant providers whose high prices became a major driver of health cost inflation.”).

⁹⁴ Robert F. Leibenluft, *Antitrust and Provider Collaborations: Where We’ve Been and What Should Be Done Now*, Duke University Press, Aug. 2015, at 847.

⁹⁵ Sherman Act, 15 U.S.C. § 1 (1890)

⁹⁶ See Leibenluft, *supra* note 94, at 847.

⁹⁷ *Id.*

⁹⁸ *Id.*

difficult for a government agency to prevail in a rule of reason case than in one alleging per se antitrust violations.⁹⁹

Section 2 of the Sherman Act prohibits any person who monopolizes, attempts to, or conspires to monopolize “any part of trade or commerce.”¹⁰⁰ According to Leibenluft, to successfully apply this provision, the entity generally must “have a share in excess of 60–70 percent in a market with significant entry barriers.”¹⁰¹ Another impediment to the application of this provision is the difficulty in defining what constitutes exclusionary conduct.¹⁰² According to Leibenluft, case law pertaining to what constitutes exclusionary conduct has been evolving and is vague, in part because “the courts are concerned about prohibiting dominant firms from engaging in conduct that restricts their ability to compete or achieve efficiencies.”¹⁰³ In applying this provision, case law has attempted to distinguish between what constitutes behavior that is anti-competitor, which is a fundamental of Capitalism, and behavior that is anti-competition, which is in violation of section 2 of the Sherman Act.¹⁰⁴

Lastly, section 7 of the Clayton Act prohibits mergers or acquisitions that substantially infringe on competition.¹⁰⁵ According to Leibenluft, in challenging such transactions, the plaintiff “must prove a case ... that the transaction will result in adverse competitive effects in a properly defined relevant product and geographic market.”¹⁰⁶ Like section 1 of the Sherman Act,

⁹⁹ *Id.* (“An agreement that involves prices or market allocations will be subject to the rule of reason ... if the agreement is related to and reasonably necessary to a collaboration among the parties that has the potential to achieve cost savings or quality improvements.”)

¹⁰⁰ Sherman Antitrust Act, 15 U.S.C. § 2 (1890)

¹⁰¹ See Leibenluft, *supra* note 94, at 848.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ Clayton Antitrust Act, 15 U.S.C. § 7 (1914)

¹⁰⁶ See Leibenluft, *supra* note 94, at 848.

applying this provision has proven to be particularly difficult, since large entities that merge or acquire are deft at detailing potential benefits to the consumer base such as quality control.¹⁰⁷

Since 1980, the FTC and the DOJ pursued enforcement actions that involved both physicians and hospitals.¹⁰⁸ Most of the enforcement actions pertaining to physicians involved those in an independent practice who had not financially integrated with one another but who had been accused of per se exclusionary conduct under section 1 of the Sherman Act.¹⁰⁹ These actions bore out of the 1982 Supreme Court decision in *Arizona v. Maricopa County Medical Society (MCMS)*. In *MCMS*, the defendant, a physician union, had established a set of maximum fees that member-doctors could accept as payment for medical services that were provided to patients.¹¹⁰ The defendant had to approve the insurance plans that patients were relying on to pay these fees.¹¹¹ The Court held that a horizontal agreement between competitors which sets out a maximum price for goods or services undoubtedly would influence competitive pricing in the market.¹¹² The Court rejected the defendant's pro-competition argument, because the per se rule applied to any agreement calling for price fixing, regardless of any pro-competitive benefits that could result.¹¹³ This holding prohibited physicians from jointly negotiating with health plans unless the physicians had a shared financial risk agreement with the insurer.¹¹⁴

This economic integration requirement led to an increase in physician and hospital mergers in the 1990s.¹¹⁵ As independent physicians needed to enhance their bargaining power

¹⁰⁷ *Id.* at 849.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Arizona v. Maricopa County Medical Society*, 457 U.S. 322, 339 (1982).

¹¹¹ *Id.*

¹¹² *Id.* at 357.

¹¹³ *Id.* at 351.

¹¹⁴ See Leibenluft, *supra* note 94, at 849.

¹¹⁵ Heather Landi, *Healthcare Leaders Look at the Past, Present and Future of Consolidation*, Fierce HealthCare (May 2, 2019), <https://www.fiercehealthcare.com/practices/healthcare-leaders-look-at-past-present-and-future-consolidation>.

with insurers, there was an incentive to consolidate.¹¹⁶ This incentive only increased after the FTC and DOJ issued the revised *Statements of Antitrust Enforcement Policy in Health Care* (1996) that reigned in the *MCMS* holding. The revision stated that “clinical integration” would be a permissible type of collaboration because of its potential to benefit consumers and therefore warranted rule of reason treatment.¹¹⁷ The agencies were reluctant to overreach and specifically defined “clinical integration” vaguely, due to their lack of knowledge of health care processes.¹¹⁸ Despite industry-wide confusion for the next decade,¹¹⁹ the *North Texas Specialty Physicians (NTSP) v. FTC* case in 2008 provided clarity into how physician groups could properly integrate. In *NTSP*, the FTC had found that certain aspects of the defendant’s non-risk contract business, combined to result in horizontal price-fixing.¹²⁰ The defendant in this case was a physician union that participated in both risk and non-risk contracts.¹²¹ The practices at issue included “the disclosure to all affiliated physicians ... results of polls to determine the minimum rates physicians would accept ... and NTSP's use of that minimum price when it negotiated with payors on behalf of physicians.”¹²² The court held that despite NTSP’s status as a “memberless” organization, a group of competitors controlled the organization, and was therefore considered to be a conspiracy of its members.¹²³ Moreover, the court found that the different medical

¹¹⁶ See Leibenluft, *supra* note 94, at 849-850. (“Very few of the cases brought by the government went to trial; instead, they generally settled with some form of consent decree that, among other things, prohibited the physicians from jointly negotiating with health plans unless the physicians were economically integrated.”)

¹¹⁷ US Department of Justice and Federal Trade Commission, FTC File No. P96503, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996), at 80.

¹¹⁸ See Leibenluft, *supra* note 94, at 850.

¹¹⁹ *Id.*

¹²⁰ *North Texas Specialty Physicians (NTSP) v. FTC*, 528 F.3d 346, 352 (5th Cir. 2008).

¹²¹ *Id.*

¹²² *Id.* at 356.

¹²³ *Id.*

specialties of board members were irrelevant,¹²⁴ and that the proper analysis was whether members with “substantially similar economic interests” controlled the entity.¹²⁵

As physician networks have consolidated, antitrust enforcement’s focus has been shifting to whether clinical integration has significant market power and is anticompetitive as reflected in a rule of reason analysis.¹²⁶ Challenges recently have been related to physician practice mergers, which have successfully enjoined hospitals’ ability to consolidate with vastly undiversified specialty clinician groups such as cardiologists.¹²⁷ As implied above, despite some successes, this analysis is difficult to apply, given the complex relationships between providers.¹²⁸

Antitrust action towards hospital mergers have had a similar record of volatility since the 1990s. After initially winning several federal lawsuits in the 1980s and early 1990s, antitrust enforcers suffered seven losses in litigating hospital merger cases.¹²⁹ According to Greaney, this led to a distinct, seven-year pullback in antitrust activity towards hospital mergers despite their accelerated growth during this time.¹³⁰ As mergers went unabated, powerful hospital networks continued to expand their market share. According to a study, sixty-five percent of Metropolitan Statistical Areas (MSAs) had highly concentrated hospital markets in 1990, and seventy-seven percent in 2006.¹³¹ In 2016, that number had reached ninety percent.¹³² Despite research that

¹²⁴ *Id.* at 357.

¹²⁵ *Id.*

¹²⁶ See Leibenluft, *supra* note 94, at 852.

¹²⁷ *Id.* see also *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke’s Health System*, 778 F.3d 775 (9th Cir. 2015)

¹²⁸ See Leibenluft, *supra* note 94, at 852.

¹²⁹ Thomas Greaney, *Coping with Concentration*, Health Affairs (Sep. 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0558>; see also William Sage, *Protecting Competition and Consumers: A Conversation with Timothy J. Muris*, Health Affairs (Dec 2003), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.22.6.101>.

¹³⁰ See Greaney, *supra* note 129.

¹³¹ Brent D. Fulton, *Health Care Market Concentration Trends in The United States: Evidence and Policy Responses*, Health Affairs (Sep. 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556>. see also Martin Gaynor, et al., *The Industrial Organization of Health-Care Markets*, The American Economic Association (Jun. 2015), <https://www.aea.org/articles?id=10.1257/jel.53.2.235>.

¹³² *Id.*

suggests otherwise, the notion that vertical integration is pro-competition has contributed to this pullback in antitrust enforcement.¹³³ Moreover, judicial mistakes pertaining to geographic market definitions enabled hospitals to consolidate.¹³⁴

There is an adage that bad facts make bad law. This was the case in 1990, when the success of the government in hospital merger cases turned on the precedent set in *U.S. v. Rockford Memorial Corp.* In *Rockford*, the issue of market definition turned on the results of a “patient flow analysis.”¹³⁵ This analysis was based on a precedent case and a contrasting study pertaining to coal markets, which measured the extent of patient ingress and egress from a proposed geographic market.¹³⁶ According to economists Dave Dranove and Andrew Sfekas, the concept behind the test was “if both flow statistics are small ... the market is deemed to be well defined, based on the assumption that if few patients travel outside the proposed market for care, the area must not have many alternative providers.”¹³⁷ The definition of “small” had varied from ten to twenty-five percent.¹³⁸ The *Rockford* court “limited the relevant geographic market to the county in which the merging hospitals operated, plus a set of zip codes from adjacent counties that contributed nontrivial numbers of patients to the Rockford area.”¹³⁹ The result was that almost ninety percent of the defendant’s admissions resided in the defined market.¹⁴⁰ Despite

¹³³ See Brown & King, *supra* note 15, at 86-88.

¹³⁴ See Greaney, *supra* note 93.

¹³⁵ *United States v. Rockford Memorial Hospital Corp.*, 898 F.2d 1278, 1283-1286 (7th Cir. 1990).

¹³⁶ *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961). See also, Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits*, *The Journal of American and Foreign Antitrust and Trade Regulation*, Vol. 18.1973, 1, 45-81 (1973); Dranove & Sfekas, *The Revolution in Health Care Antitrust: New Methods and Provocative Implications*, US National Library of Medicine National Institutes of Health (Sep. 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881459/#fn2>.

¹³⁷ See Dranove & Sfekas, *supra* note 136.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

there being four other hospitals in the defined market, the court held that the change in market consolidation was untenable.¹⁴¹

It is important to note that, according to Dranove and Sfekas, “The hospital mergers contested by the FTC and DOJ during the 1990s tended to involve smaller metropolitan areas with two to four hospitals that drew more than 10 percent of their patients from surrounding communities.”¹⁴² This is relevant because not all geographic areas are the same. What makes sense in rural areas is not necessarily the case in densely populated suburban regions. Antitrust suits that held similar holdings to *Rockford* included many hospitals far outside the metropolitan areas at issue, making it appear that the merging hospitals had not consolidated the market.¹⁴³ This enabled suburban and urban area hospital networks to merge without concern. For example, the courts permitted the merger of two Long Island hospitals based on the grounds that the patient-flow and geographic market analysis included much of New York City.¹⁴⁴ According to Greaney, “courts were too easily persuaded to find overbroad geographic markets—which spurred others to undertake concentrative acquisitions and likely caused government prosecutors to forgo challenging hospital mergers for almost seven years.”¹⁴⁵ The trends in consolidation, which are detailed above, support this conclusion.

The issues that antitrust enforcement have had in applying these laws, as implied above, are that most transactions that potentially infringe on competition are subject to much more extensive analysis. Since antitrust enforcement players have a burden to prove exclusionary

¹⁴¹ See *Rockford Memorial Hospital Corp.*, *supra* note 135, at 1284-1285.

¹⁴² See Dranove & Sfekas, *supra* note 136.

¹⁴³ *Id.*

¹⁴⁴ *U.S. v. Long Island Jewish Medical Center*, 983 F. Supp 121 (E.D.N.Y. 1997). (District Court holding, *inter alia*, that there were other medical care facilities entering the relevant geographic market resulting from the increasing movement of Manhattan hospitals into Long Island.)

¹⁴⁵ See Greaney, *supra* note 93.

conduct, there are a litany of relevant factors that must be considered. These include product and geographic markets, transaction details such as timeliness, efficiency assessment, and the overall effect the transaction will have on competition.¹⁴⁶ This can cause a strain on resources that may be outside the bounds of the government's legal economy. Additionally, there are no special antitrust laws for the health care industry specifically. Leibenluft explained this dilemma: "Both the courts and the enforcers interpret the antitrust laws when applied to health care with the knowledge that they are bound by precedent—and that their actions may create precedent—in cases involving other industries."¹⁴⁷ Therefore, the uniqueness and complexity of the health care industry has disincentivized courts to pursue stricter holdings in cases relating to provider mergers. According to Leibenluft, it has also influenced law enforcement's pursuit of antitrust claims: "The application of antitrust law to any particular set of circumstances is often a difficult task and is particularly so in the health care sector given the overlay of regulation, agency relationships, asymmetrical information, government payment, and other factors that result in various market failures."¹⁴⁸

II. Addressing the Proposed Solutions to Health Care's High Prices

Fortunately, despite the enduring nature of concentrated provider markets, solutions have been proposed to address them. Notably, Senator Bernie Sanders ran presidential campaigns in 2016 and 2020 largely around his proposal to expand a revised version of Medicare to all American citizens. The Medicare for All Act of 2019, which is the version Senator Sanders last proposed, would largely do away with private insurance and consolidate almost all public plans into one.¹⁴⁹ President Joe Biden ran his 2020 presidential campaign on a proposal, *inter alia*, that

¹⁴⁶ See Leibenluft, *supra* note 94, at 848.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ See Medicare for All Act of 2019, S. 1129, 116th Cong. § 107(a) (2019).

would offer a public insurance option to Americans, while opting qualified citizens whose states have decided against Medicaid Expansion into the public option.¹⁵⁰

Those on the other end of the political spectrum have proposed ideas that in practice take a more piecemeal approach to solving the issue of price and consolidation. Avik Roy, who is a former adviser to the Mitt Romney and Marco Rubio presidential campaigns¹⁵¹, has proposed a multi-pronged approach that includes further demands for transparent pricing, heightened antitrust enforcement, and regulatory reform.¹⁵² Moreover, Roy proposes Medicare Advantage for All, which would provide uninsured Americans sufficient subsidies on a sliding scale that would allow consumers to choose amongst existing Medicare Advantage plans.¹⁵³ Ideally, these changes would lower barriers to entry for competitors and lower prices. Additionally, Dr. Ryan Neuhofel, has proposed decentralizing the management of health care dollars through a universal direct primary care model.¹⁵⁴ The direct primary care model eliminates third parties and lets consumers purchase non-catastrophic services through their primary care physician.¹⁵⁵

a. Checking Quasi-Monopolies with a State-Sponsored Monopsony is Counterintuitive

The theory at the heart of both Biden and Sanders' plans is twofold: use the state's buying power to negotiate down prices and use monopsony purchasing to promote price uniformity. Under Sanders's proposal, Medicare for All would in practice, be a single, national

¹⁵⁰ Joe Biden for President, *Health Care* (2020), <https://joebiden.com/healthcare/>.

¹⁵¹ Avik Roy, *FREOPP Leadership: Avik Roy* (Sep. 12, 2016), <https://freopp.org/the-freopp-founders-avik-roy-53719dfcaf05>.

¹⁵² Avik Roy, *Affordable Hospital Care Through Competition and Price Transparency* (Jan. 31, 2020), <https://freopp.org/affordable-hospital-care-through-competition-and-price-transparency-765714c69ed8>.

¹⁵³ Avik Roy, *Medicare Advantage: A Platform for Affordable Health Reform* (Apr. 18, 2019), <https://freopp.org/medicare-advantage-a-platform-for-affordable-health-reform-fbe31bf444f3>.

¹⁵⁴ W. Ryan Neuhofel, *A Radically Patient-Centered Proposal to Fix Health Care in America* (Jul. 26, 2017), Medium, <https://medium.com/@NeuCare/a-radically-patient-centered-proposal-to-fix-health-care-in-america-8e4df6130b4a>.

¹⁵⁵ American Academy of Family Physicians, *Direct Primary Care* (2018), <https://www.aafp.org/about/policies/all/direct-primary-care.html>

health insurance program that would cover everyone living in the United States.¹⁵⁶ The bill makes it unlawful for “any private insurer to sell health insurance coverage that duplicates the benefits provided under this Act.”¹⁵⁷ The proposal eradicates copays and deductibles, except for prescription drugs, though the maximum cost would be \$200 annually.¹⁵⁸ This is a reform to traditional Medicare, which has no out-of-pocket limits and imposes high deductibles and copayments.¹⁵⁹ Sanders’s egalitarian approach would likely simplify the point-of-care transactional process, because of consumers’ ability to utilize any providers’ services.¹⁶⁰ Additionally, the statute includes “a process for the automatic enrollment of individuals”¹⁶¹, which would, in theory, further simplify the health care purchasing process, as consumers would not have to consider the status of their private insurance plan.

Sanders’ state-sponsored insurance bill guarantees coverage of an array of potential health care needs including inpatient and outpatient hospital services, ambulatory patient services, primary and preventive services, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, comprehensive maternity and newborn care, pediatrics, dental and vision, and short-term rehabilitative and habilitative services and devices.¹⁶² The proposal also includes emergency services and necessary transportation for individuals with disabilities and of low-income.¹⁶³ The Secretary of Health and Human Services (HHS) would be tasked with recommending reforms to the benefits package for lawmakers to consider.¹⁶⁴

¹⁵⁶ See Medicare for All Act of 2019, *supra* note 149, at § 105(a).

¹⁵⁷ *Id.* at § 107(a).

¹⁵⁸ *Id.* at § 202(a) and (b).

¹⁵⁹ See Furrow, et al., *supra* note 1, at 637.

¹⁶⁰ See Medicare for All Act of 2019, *supra* note 149, at § 103.

¹⁶¹ *Id.* at § 105 (a)(1).

¹⁶² *Id.* at § 201(a).

¹⁶³ *Id.*

¹⁶⁴ *Id.* at § 201(b).

Moreover, the bill would drastically alter the relationship between payer and provider. Under the proposal, the government would set service rates paid to doctors, hospitals, and pharmaceutical companies for services provided.¹⁶⁵ These rates would be delivered in two annual lump-sum payments, which would cover the cost of operations and capital expenditures.¹⁶⁶ Instead of billing insurers, doctors would only need to send reimbursement invoices to the federal government. This would likely set lower payments to providers than currently realized with private insurance companies.¹⁶⁷ Additionally, under the bill, patients would be permitted to contract with physicians outside the structure of the proposal.¹⁶⁸ However, those providers who agree to private contracts with consumers will not be permitted to participate in the nationalized insurance plan for a year.¹⁶⁹ This provision appears to be a hedge against fears that physicians will decide against contracting with the insurance plan.

Sanders's plan, despite its political potency, is not likely to pass Congress, given its sweeping changes to an industry that employed over 20 million Americans in 2018.¹⁷⁰ Regardless of the bill's likelihood to pass through Congress, the proposal is misguided for several reasons. The first is that quality could be affected if the budgeted amount allocated to the provider proves to be insufficient to cover its total costs. In case of a budget gap, the provider would be at-risk for the unpaid expenses, which would likely lead to dialed back services or cuts to necessary overhead. These issues have been realized recently in Britain and has led to

¹⁶⁵ *Id.* at § 611(a).

¹⁶⁶ *Id.*

¹⁶⁷ Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*, (May 2019), at 22.

¹⁶⁸ See Medicare for All Act of 2019, *supra* note 149, at § 303(a).

¹⁶⁹ *Id.* at § 303(c).

¹⁷⁰ See Earlene K.P. Dowell, *Census Bureau's 2018 County Business Patterns Provides Data on Over 1,200 Industries*, United States Census Bureau (Oct. 14, 2020), <https://www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html>.

increased wait times for certain medical services.¹⁷¹ Rebuttals to these concerns will likely mention savings in administrative overhead, such as medical billing, as potential supplemental resources that providers could rely on to strengthen their bottom lines. However, there is no guarantee that those resources will be enough to cover a provider's given costs. Moreover, the cost of taxation needed to establish the requisite bureaucracy could negate the expenses beneficiaries save in administrative overhead. This is the risk that comes with completely disassociating the provider from deciding the price of services.

Additionally, the bill will inevitably increase service demand at a time when those who provide the service are already being underpaid. According to a 2021 American Hospital Association (AHA) report, in 2019, hospitals incurred \$56.8 billion in underpaid costs for delivering care to Medicare patients.¹⁷² Moreover, despite Medicare's ability to control prices through government buying and regulatory power, the program has been less successful at controlling the volume of services it covers.¹⁷³ This issue will only persist under Sanders's plan, which, entails no cost-sharing mechanisms such as deductibles or co-payments¹⁷⁴ but offers an incredibly generous benefit package to every American.¹⁷⁵ These demand side mechanisms require patients to have skin-in-the-game and can provide a check on overutilization of services that patients request, and doctors recommend. According to Drew Altman, who heads the Kaiser Family Foundation, "no other developed nation has zero out of pocket costs."¹⁷⁶ Moreover, under the proposal, the government would further regulate the physician labor force and quantify the

¹⁷¹ Roosa Tikkanen, et al., *2020 International Profiles of Health Care Systems*, The Commonwealth Fund, Dec. 2020, at 67.

¹⁷² American Hospital Association, *Fact Sheet: Underpayment by Medicare and Medicaid* (Jan. 2021), <https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid>.

¹⁷³ See Burrow, et al., *supra* note 1, at 643.

¹⁷⁴ See Medicare for All Act of 2019, *supra* note 149, at § 202(a) and (b).

¹⁷⁵ *Id.* at § 201(a).

¹⁷⁶ Sarah Fisher, *Medicare for All: Definition and Pros and Cons* (Oct. 6, 2020), SmartAsset, <https://smartasset.com/insurance/medicare-for-all-definition-and-pros-and-cons>. See also, Tikkanen, *supra* note 171.

need for specialists in areas of practice.¹⁷⁷ Although this paper supports a heightened reliance on general practitioners, it remains to be seen how these regulations would affect the clinician labor market and the ability to supply medical services. It is likely that an increase in labor supply would be needed under this plan, given the increase in consumers¹⁷⁸ and the plan's extended benefits.¹⁷⁹

Given its scope, it is difficult to grasp the effects of Sanders's proposal in its entirety. The impetus behind this bill is the belief that health care is a right, but this is misguided. While rights are inalienable, services are not; they are not innovative, efficient, and present simply because a statute says they ought to be. Supply, demand, and behavioral science all affect the development and sustainability of an industry. To provide a metaphorical example, the City of Newark and the State of New Jersey combine to spend over \$25,000 annually per pupil to graduate just sixty percent of their high school students.¹⁸⁰ The funding is more than adequate, but the service is not. Institutionalized special interests protect the status quo to their benefit at the expense of quality, which this paper fears would happen to the healthcare industry under Sanders's proposal. To solve the issue of coverage gaps and general costs, policy makers should be adamantly focused on decentralizing the management of health care dollars and grant consumers greater discretion. This bill does the exact opposite and demands the nationalization of an industry that employs eleven percent of the U.S. workforce. It assumes that central planners can use wide-ranging price controls and regulatory efforts to manage the cost and quality of medical services provided to over 320 million Americans. Monopsony typically leads to a decrease in services provided as

¹⁷⁷ See Medicare for All Act of 2019, *supra* note 149, at § 613(a).

¹⁷⁸ *Id.* at § 105(a).

¹⁷⁹ *Id.* at § 201(a).

¹⁸⁰ Chris Christie, *Star-Ledger, Liberals Wrong on School Funding*, NJ.com (Jul. 3, 2016), https://www.nj.com/opinion/2016/07/christie_star-ledger_liberals_wrong_on_school_fund.html

suppliers cannot sustain the buyer's leverage to fix prices.¹⁸¹ This paper sees no reason to believe that the medical industry would be an exception.

b. The Dog Chasing its Tail is Getting Exhausted

Although President Biden's plan for healthcare reform has yet to be drafted into legislation, his campaign website still provides some detail into how he believes America ought to deal with concentrated health care markets. His proposal suggests similar state-sponsored purchasing as Sanders's plan, albeit far less expansive and universal. The proposal introduces a public insurance option for Americans who seek an alternative from the existing private or employer-sponsored marketplace.¹⁸² The proposal lacks finite detail such as the cost of premiums for beneficiaries and the services that would be covered under the plan.¹⁸³ However, the plan would use the state's power to negotiate down prices that providers charge.¹⁸⁴ Moreover, those who qualify for Medicaid in states that have not yet expanded the program under the ACA will be automatically opted into the public option, premium free.¹⁸⁵

The plan also proposes reforming the eligibility standards for those who purchase health insurance in the individual marketplace.¹⁸⁶ Specifically, the plan eliminates the income eligibility threshold for those who qualify for supplemental tax credits under the ACA.¹⁸⁷ Under current ACA provisions, families who make between 100% to 400% of the federal poverty line qualify for subsidies.¹⁸⁸ These benchmarks are based on percent of income spent on their insurance

¹⁸¹ Corporate Finance Institute, *What is Monopsony?*, <https://corporatefinanceinstitute.com/resources/knowledge/economics/monopsony/>.

¹⁸² See Joe Biden, *supra* note 150.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

premiums.¹⁸⁹ Under President Biden’s reforms, subsidy eligibility would be based solely on percent of family income spent on health care.¹⁹⁰ The threshold would be lowered from 9.86% of income to 8.5% of income.¹⁹¹ Therefore, no family will have to spend more than 8.5% of their income on health insurance.¹⁹²

This paper disagrees with the public option proposal because of the inevitability that it will lead to a single-payer controlled system. If the government can set rates that undercut current price levels, that is a benefit to consumers. However, the concern is that this will lead the program to become a monopsony like what Senator Sanders has proposed. Jonathan Gruber, the Massachusetts Institute of Technology economist who designed the ACA, reported that when government insurance expands, six people go off private insurance for every ten people who go on public insurance.¹⁹³ As discussed above, lowering the price of services provided at the expense of quality will only create a new set of problems for consumers and the system writ large. However, the public option would likely require cost-sharing mechanisms, which would limit the perverse effects that the Sanders proposal would entail.

Additionally, the plan to extend subsidy eligibility is a metaphorical dog-chasing-tail scenario. These broadened eligibility requirements continue to try to catch the runaway costs of healthcare as those who purchase insurance on the individual marketplace struggle to afford comprehensive coverage. Although it is understandable that the price issue is incredibly difficult to solve, simply throwing more money at the problem is a short-term fix for a long-term

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* (Jan. 2017), National Bureau of Economic Research, <https://www.nber.org/papers/w12858>.

problem. It is important to help Americans pay for their health care expenses, but if it happens at the expense of taxpayers, this becomes counterintuitive. Unfortunately, these incremental reforms mostly preserve a fundamentally broken system. Despite this, President Biden's plan to utilize aggressive antitrust measures to combat concentration in the provider market¹⁹⁴ is a welcome development.

c. Say Their Names: Provider Monopolies are Utilities

Avik Roy, former healthcare advisor to both Mitt Romney and Marco Rubio's presidential campaigns, has proposed aggressive measures to tackle the concentrated provider market. These reforms would increase supply-side competition and lower prices charged to those insured under private insurance plans. The foundation of Roy's proposal is Medicare Advantage for All¹⁹⁵, which this paper does not go into in full detail, but will be cited to throughout this section. Medicare Advantage for All would evolve the health care system in a direction that enables more Americans to choose among a wide variety of insurance plans that suit their needs, like how those enrolled in Medicare Advantage can today.¹⁹⁶ The plan takes the appealing elements of the Biden and Sanders proposals, such as streamlined overhead,¹⁹⁷ but decentralizes the management of insurance dollars, which is vital to service quality.¹⁹⁸

To address existing consolidated markets, Roy proposes that the FTC regulate certain mega-systems essentially as utilities.¹⁹⁹ He suggests that the systems be given two options: remain consolidated, but without monopoly pricing power; or voluntarily divest some holdings

¹⁹⁴ See Biden, *supra* note 150.

¹⁹⁵ See Roy, *supra* note 153.

¹⁹⁶ *Id.*

¹⁹⁷ See Medicare for All Act of 2019, *supra* note 149; See also Biden, *supra* note 150; See also, Roy, *supra* note 153.

¹⁹⁸ See Roy, *supra* note 153.

¹⁹⁹ See Roy, *supra* note 152.

to restore competition to their hospital market.²⁰⁰ “If a hospital market concentration ... region exceeds an extremely high threshold ... hospitals in that region with >15 percent market share would be required to accept rates ... that are equal to or less than the median rate paid by a Medicare Advantage plan in that region.”²⁰¹ The proposal suggests that, “These regional monopolies or oligopolies would remain free to charge less than Medicare Advantage rates, or to engage in value-based insurance contracts with an aggregate spend that remains below Medicare Advantage rates.”²⁰² Under the plan, the Medicare Advantage fee benchmark would be phased in over a seven-year period.²⁰³ If the system chose to divest, they would be required to bring hospital market concentration in their region below a certain threshold.²⁰⁴

To prevent further market consolidation, Roy proposes a national all-payer claims database (APCD) that delivers full transparency into contracts negotiated between providers and insurers.²⁰⁵ This could help aid the FTC, given the resources it would take to review each contract for anticompetitive practices. Moreover, according to Roy, “The claims database would serve the additional purpose of creating price transparency for private insurers, allowing more efficient competition, especially from new entrants and other startups.”²⁰⁶ This would increase the leverage of less established insurers as they could better ascertain what certain providers are charging their competitors. This APCD structure would be legal under *Gobeille v. Liberty Mutual Insurance Company*, which held that The Employee Retirement Income Security Act of

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Id.*

1974 (ERISA) preempts state law requiring disclosure of payments relating to health care claims.²⁰⁷

Next, like President Biden, Roy suggests increased antitrust enforcement to discourage further hospital and physician group consolidation. The proposal would quadruple funding for the FTC, while restricting that funding to hire hospital industry specialists: “Expanding staffing at a government agency may seem like a counterintuitive way to increase market competition, but antitrust litigation is an important, and underutilized, tool for combating anticompetitive hospital practices.”²⁰⁸ Increased litigation efforts could push courts to review the mistakes made in healthcare antitrust cases such as *Rockford*, which was discussed above. A change in healthcare antitrust case law could reverse the consolidation trends the industry has realized since the move towards enhanced vertical integration and the incentives given to providers to formulate ACOs.

Roy also proposes other piecemeal reforms that should prevent further consolidation and reverse current trends in the healthcare marketplace. These reforms include repealing regulations that create barriers to entry for new providers such as state certificate of need, any willing provider, and network adequacy laws.²⁰⁹ These laws require insurers to include in-market providers, regardless of the leverage that those providers may have over the insurer.²¹⁰ Additionally, the proposal calls for increased usage of telemedicine and medical tourism to enable patients to purchase medical services outside of their region.²¹¹

²⁰⁷ See, e.g., *Gobeille v. Liberty Mutual Insurance Co.*, 577 U.S. 312, 325-327 (2016).

²⁰⁸ See Roy, *supra* note 152.

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Id.*

d. Empower Consumers to Dilute the Power of the Monopolies

Dr. Ryan Neuhofel's proposal is another consumer driven plan that thwarts market centralization while maintaining quality of service. Dr. Neuhofel is a direct primary care physician, who provides health care to patients without a third-party insurer.²¹² Like concierge medicine, Dr. Neuhofel charges a monthly membership fee to patients at an average rate of \$43 per member per month.²¹³ This fee covers an array of basic and ancillary services such as labs and radiology at wholesale rates.²¹⁴ If a patient desires an additional service outside of the negotiated benefit package, the physician provides it at a cost.²¹⁵ The model, which Dr. Neuhofel refers to as Direct Primary Care (DPC), is a bottom-up approach that he refers to as "a metaphorical Costco of primary care."²¹⁶ The model reduces administrative overhead and eliminates most billing, coding, and regulatory compliance requirements that interfere with quality of care while increasing costs. Moreover, it puts a greater onus on general practitioners to deliver care for patients, as opposed to our current structure of overreliance on specialists. This would reverse the trend of treating primary care providers as essential "referralists", as Dr. Neuhofel puts it.²¹⁷ Additionally, the model provides transparent pricing for consumers.²¹⁸

To make this reform proposal universal, Dr. Neuhofel proposes public health savings accounts for every American that would be supported with government subsidies, if necessary.

²¹⁹ Moreover, Dr. Neuhofel proposes a Medicare-for-catastrophic-for-all to cover emergency and

²¹² Ryan Neuhofel, *NeuCare: Our Story*, <http://neucare.net/about>.

²¹³ Interview by Zubin Damania with Ryan Neuhofel, Primary Care Physician and Founder of NeuCare, in Las Vegas, NV. (Oct. 2, 2017).

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *See* Neuhofel, *supra* note 154.

catastrophic health care needs.²²⁰ This paper does not go into the plan in full but will be cited throughout for reference purposes. As discussed earlier, vertical integration has become a talking point for provider networks who seek to enhance market leverage. Although some aspects of vertical integration have been necessary, other aspects have directly led to increase in prices and concentrated markets.²²¹ This proposal would reverse excessive trends of vertical integration and would rely on contractual affiliation between providers²²², as opposed to direct acquisitions. This would temper fears of going back to fragmented health care. Moreover, this structure would allow for decentralization of health care dollars, which would weaken the market power of existing provider networks. Managed care structures keep money in the hands of central players, which inherently raises costs as middlemen such as Pharmacy Benefit Managers get their hands in the pot. Our current structure requires third-party payers to pay for services that could be provided for cheaper over the counter. This would be as if consumers relied on home insurance to pay for new windows and doors. If certain services can be provided without third parties, then the system should support it. The DPC model does just this.

CONCLUSION

The conversation surrounding the cost of health care in the United States cannot ignore the issue of prices charged for services. As providers have been incentivized to consolidate, their leverage has increased. This has had perverse effects on consumers who are insured through private plans. Moreover, the absence of assertive antitrust measures and judicial mistakes have enabled further consolidation. All of this has led to further concentrated insurance markets as well. To reverse these trends, policymakers ought to pursue consumer driven proposals that

²²⁰ *Id.*

²²¹ See Brown & King, *supra* note 15, at 88-91.

²²² See Neuhofel, *supra* note 154.

divest power in the hands of a few monopolies. Avik Roy and Dr. Ryan Neuhofel's proposals are a good place to start to lower the prices of medical services provided in the United States.