

# Antitrust and the Most Common Type of Hospital Combination

*By Guest Blogger: Steven Brodsky*

## Overview

The trend toward increasing concentration in hospital markets has spiked in recent years.<sup>[1]</sup> That trend consists largely of transactions in which each of the combining hospitals is, by virtue of its location, services or reputation, uniquely able to fill a slot health plans need to fill in their provider networks. (For example, there is just one hospital on the east side of town and just one on the west side|health plans need each of them - and they combine to form a multiple-hospital “health care system.”)

Health plans complain that these combinations are anticompetitive|and their complaints are supported by some commentators,<sup>[2]</sup> early studies,<sup>[3]</sup> and anecdotal news reports.<sup>[4]</sup> The antitrust enforcement agencies have not explicitly challenged one of these transactions - perhaps because they do not fit a traditional antitrust paradigm of an anticompetitive combination. But the 2010 DOJ/FTC Horizontal Merger Guidelines do not require that a challenged transaction fit a traditional paradigm. And a recent analysis by a prominent healthcare/antitrust economist explains why such a combination can be anticompetitive.<sup>[5]</sup>

On the other side of the ledger, such a combination may not offer substantial benefits that would outweigh its potential anticompetitive effects. Hence, antitrust enforcement agencies should reconsider the competitive issues posed by this common type of hospital combination.

## Market Definitions

### *The Relevant Product Market*

The first step in a traditional antitrust analysis of a proposed combination is to “define the relevant product market.” That definition should identify the requirement(s) the combining firms fulfill for their price-sensitive customers. For a

hospital combination, the case law defines the relevant product market as “general acute care inpatient hospital services” or a subset thereof. That product market definition overlooks the most important customer requirement at issue when a health plan negotiates with a hospital: the hospital’s *participation in the health plan’s network*.

Hospitals’ principal price-sensitive customers are “contract model” health plans that are marketed to employers. Such a health plan negotiates with hospitals, physicians and other healthcare providers over the terms on which the provider *will agree to participate* in the health plan’s provider network.

Such a health plan must develop a provider network that meets employers’ demands (which reflect their employees’ demands). So, for each network slot a health plan needs to fill to meet employers’ demands, it must obtain *the participation of a provider* that can fill that network slot. A hospital that is uniquely able to fill such a network slot (hereinafter a “sole source hospital”) will, *ipso facto*, enjoy the market power to extract above-market rates. Thus, the relevant product market definition – the operative customer requirement – is a hospital’s “network participation.”

The distinction between “inpatient services” and “network participation” can be illustrated by imagining how a sole source hospital would maximize its revenue in normal market conditions. First, for its *services*, it would charge a health plan *the market price*. Otherwise a health plan may be able to at least partially substitute the services of lower cost hospitals. But the hospital would also demand a separate fee – an annual “signing bonus” – *for its agreement to participate* in a health plan’s network. Since no other hospital can fulfill that requirement, a health plan would not be able to evade that above-market-price demand.[\[6\]](#)

### ***The Relevant Geographic Market***

The relevant geographic market is the geographic area within which a firm that supplies the same product(s) or service(s) must be located to compete with the combining firms. For lower-level inpatient services, the courts adopted large relevant geographic markets that typically include numerous hospitals. In reality, the relevant geographic market for hospitals that provide those services is very small – it often includes only one hospital.

Before describing the basis for that assertion it will be useful to address the two fundamental errors that led the courts to adopt large geographic markets.

The courts' first error was their assertion that a sole source hospital would be deterred from demanding an above-market price by the prospect of "in-network steering." That is, if a sole source hospital demanded an above-market price, a health plan could obtain its participation *by agreeing to its demand for an above-market price*. But then, the courts reasoned, the health plan could "defeat" that above-market price by employing in-network steering (such as offering even lower co-pays) to redirect enrollees to its lower priced participating hospitals. It would only have to redirect a small number of enrollees - just enough to make the sole source hospital's above-market price unprofitable.

But a sole source hospital (or a health care system) may enjoy enough market power to extract two different conditions for its agreement to participate in a health plan's network: (1) the health plan's agreement to pay an above-market price for the hospital's services and (2) the health plan's commitment *not to employ in-network steering*. [7] The hospital (or health care system) would not earn as much as it would earn if, instead of using up some of its market power to demand a no-in-network-steering provision, it could have used *all* of its market power to demand an above-market-priced signing bonus. (See text adjacent to note 6.) But it would be able to successfully demand an above-market price. [8]

The other fundamental error was the courts' focus on home-to-hospital travel time as a determinant of market size. Antitrust enforcement agencies argued that the geographic market is small because enrollees are unwilling to travel far from home for lower level inpatient services. The courts responded by citing patient origin data that shows that many metropolitan area patients obtain at a hospital far from their homes lower level inpatient services they could have obtained at a hospital near their homes. But that debate may be beside the point. For other factors may be more important determinants of market size.

Since lower level inpatient services is not the correct *product market* definition, it is better to define a relevant *geographic market* for the hospitals that primarily provide those services. They are "full service hospitals" that provide primary and secondary

services, and, in many cases, several tertiary-level services. Typically those hospitals are widely distributed throughout a metropolitan area, with each one serving as the home base for nearby physicians. (I will refer to the area that encompasses one of those hospitals and its nearby physicians as a “hospital/physician sector.”)

An important determinant of market size for those hospitals may be health plans’ *physician network requirements*. That is so because health plans generally require their participating physicians to be on staff at one of their participating hospitals|and if a large proportion of the physicians in a hospital/physician sector are on staff only at that sector’s lone hospital, a health plan will need to secure that *hospital’s* participation in order to recruit an ample panel of that sector’s *physicians*.

If health plans need an ample panel of participating physicians in such a sector in order to satisfy employers’ physician network demands, and if, to satisfy that physician network demand, health plans need the participation of that sector’s lone hospital, then in traditional antitrust terminology, that hospital/physician sector is a relevant geographic market for full service hospitals, with just one (monopoly) market participant. However, it may be more useful (though less traditional) to think of a *network slot* that health plans need to fill as a relevant market, and to think of the provider(s) that can fill that slot as market participants.

That geographic market analysis is significant if health plans need an ample panel of physicians in, and therefore need the hospital in, each of a large proportion of a metropolitan area’s hospital/physician sectors. In the early days of managed care (and perhaps even now in a sustained period of slow economic growth), a health plan could make do with one hospital for two or three adjacent hospital/physician sectors, even though enrollees in the sectors whose hospital was not selected might have to travel to the one whose hospital was selected for an adequate choice of participating physicians. But when labor markets are relatively tight, a health plan is likely to need an ample panel of physicians in most of, if not the great majority of, a metropolitan area’s hospital/physician sectors.

That is so for three overlapping reasons: (1) Most employers now offer their employees only one contract model health plan|hence, such a plan’s network must meet the needs of *all* of an employer’s existing and prospective employees,

regardless of where they live or want to select a physician|(2) An employer may draw employees from throughout the metropolitan area|and many of them will expect an ample choice of physicians near where they live|and (3) Many enrollees also demand an ample choice of physicians in other, unpredictable, locations, such as near where an enrollee's spouse, or adult child under age 26, works.[\[9\]](#)

Finally, many enrollees may expect their employer's health plan to include a *hospital* near where they live even if they are not highly sensitive to home-to-hospital travel time for inpatient services. They may be sensitive to home-to-hospital travel time for emergency room services.[\[10\]](#) Or, they may be familiar with the hospital near their home, and unfamiliar with more distant full service hospitals, or unfamiliar with the neighborhoods in which those more distant hospitals are located. This, too, would mean that the relevant geographic markets for full service hospitals are small.

### ***Reconsidered Market Definitions for Sole Source Hospitals***

The 2010 Merger Guidelines recognize that in some types of markets, defining relevant product and geographic markets may not be a good starting point for an antitrust analysis. That is so for health care markets. But one can "reverse engineer" for sole source hospitals relevant markets at two different levels.

At one level, a hospital that is uniquely able to fill a network slot a health plan needs to fill is, by definition, a monopolist in a one-hospital market. Or, for the more traditional reasons offered above, one can say that at this level the markets for full service hospitals will often be one-hospital markets.

At a second level, a metropolitan area's sole source hospitals resemble participants in a single, metropolitan-area-wide relevant market. They are interchangeable (or, in antitrust terminology, they are "substitutes") that constrain one another's rates in this sense: A health plan's overriding objective is to create a metropolitan-area-wide provider network with as few unfilled slots (or "network holes") as possible, and with respect to that objective, a network hole in one part of a metropolitan area is no different than one (of comparable importance) in another part. Thus, if, in relative terms, one sole source hospital's prices get ahead of the prices at the metropolitan area's other sole source hospitals, the high priced sole source hospital risks being one that health plans will decide to do without. And, for the reason described below,

if any of a metropolitan area's sole source hospitals combine, they will gain additional market power (or "bargaining leverage").

### **Sole Source Hospitals Increase Their Bargaining Leverage When They Combine**

In a 2013 article, prominent healthcare/antitrust economist Greg Vistnes and his colleague Yianis Sarafidis explain why a combination among any of a metropolitan area's sole source hospitals may have an anticompetitive result.[\[11\]](#)

The explanation begins with the fact that an *individual* sole source hospital can extract a price that is above the market level by the amount it will cost a health plan (e.g., in lost sales) to do without it. It follows that if a sole source hospital can increase the cost a health plan would incur because of its absence, it will be able to charge an even higher above-market price.

If two or more of a metropolitan area's sole source hospitals combine to form a multiple-hospital health care system, *the system's* absence will leave *multiple holes* in a health plan's provider network. The cost of those multiple network holes, Vistnes and Sarafidis observe, will at least sometimes (health plan officials would say *always*) be greater than the sum of the amounts each of those network holes would have cost by itself. Thus, such a combination will increase the cost to a health plan of the combined hospitals' absence, and that will enable them to extract even higher prices than they could have extracted individually.

### **Efficiencies**

Some commentators assert that multiple-hospital health care systems can achieve substantial quality or efficiency benefits.[\[12\]](#) If that is so, and if those benefits cannot be achieved in other ways, they must be weighed against the prospect that a particular hospital combination will be anticompetitive. I will respond to three of the principal benefits advanced by proponents of multiple-hospital health care systems.

(1) Service Consolidation: Proponents assert that when multiple hospitals combine to form a health care system, they can consolidate at one location any service(s) they previously were duplicating at less than optimal volume. That is true when hospitals

that are quite close to each other formally merge. But instead of a *bona fide* merger, some health care systems were formed pursuant to a “Joint Operating Agreement” that prevents the system’s governing authority from closing an underutilized service at one of its member hospitals unless that hospital assents|and, it may not be in that hospital’s interest to do so.[\[13\]](#) Moreover, service consolidation may not be practical when, as is often true, each of a health care system’s hospitals serves a different part of the metropolitan area.

(2) Quality & Efficiency Monitoring: It has been argued that when hospitals combine, they can pool their resources to develop a system to monitor their quality and efficiency. But there is little evidence that those joint monitoring programs have been effective. And, in any event, an individual hospital may be able to obtain comparable monitoring services from a health care analytics firm.

(3) “Population Management” Arrangements: Proponents point out that a multiple-hospital health care system can enter into certain types of efficiency-promoting arrangements with health plans. For example, under a “global capitation” arrangement, a health plan would pay a multiple-hospital health care system a flat monthly per capita fee for each covered enrollee|and out of that money, the health care system would provide for those enrollees’ medical and hospital needs. In theory, the health care system’s incentive will be to keep the covered enrollees well and out of the hospital, and to provide hospital services efficiently when they are needed. But there is a fly in the ointment: If a health care system has gained the bargaining leverage to impose above-market prices, the incentive to achieve efficiencies will be dulled. And any efficiencies it does achieve will not benefit consumers in the form of lower prices.

Moreover, health plans can enter into a global capitation or similar arrangement with *physicians*.[\[14\]](#) The physicians will have the same incentive to keep the covered enrollees well and out of the hospital, and an incentive to monitor a hospital’s efficiency when it treats a covered enrollee. Additionally, the physicians will choose the most cost effective of the hospitals to which they have access (see note 15), which will force those hospitals to compete for the physicians’ business.[\[15\]](#)

In short, some of the ostensible efficiency or quality benefits of multiple-hospital health care systems are overstated, and some are achievable in other ways that won't stifle (or that will *promote*) competition.

## **Conclusion**

Many multiple-hospital health care systems are a combination of sole source hospitals. When such hospitals combine, that will increase their bargaining leverage and enable them to secure even higher prices from health plans. On the other side of the ledger, some of the ostensible quality or efficiency benefits of multiple-hospital health care systems are overstated, or can be achieved in other ways. Antitrust agencies should reexamine this issue, and that examination should not be bound by existing hospital merger precedent, which does not reflect actual hospital market conditions.

[1] See: <http://www.kaufmanhall.com/about/news/number-of-hospital-transactions-remains-high-in-2014>|Anna Wilde Mathews, *Health Law Speeds Merger Frenzy*, September 22, 2015 WSJ, p.B1.

[2] See, e.g.: Suzanne Delbanco op ed, October 1, 2014 WSJ at p.A-15. Cf.: Marty Makaray op ed, April 20, 2015 WSJ, p. A-13. But compare Kenneth Davis op ed, September 16, 2014 WSJ, p. A-15.

[3] See studies cited in Delbanco op ed, **note 2** above.

[4] See, e.g., Andrew S. Ross, *Hospital Prices under Scrutiny*, December 4, 2013 San Francisco Chronicle, p. C1.

[5] Vistnes & Sarafidis, *Cross-Market Hospital Mergers, a Holistic Approach*, 79 Antitrust L. J. 253, Dec. 2013.

[6] Hospitals and health care systems that enjoy market power have not followed that profit-maximizing approach because of quasi-political and regulatory "externalities." A hospital that demanded a large signing bonus for its agreement to participate in a health plan's network would be wearing its market power on its sleeve|and that could provoke a reaction from the public, from regulators, or from state legislatures.



**[7]** That is exactly what one prominent health care system did after a District Court approved its acquisition of an additional hospital – in part on the ground that health plans could employ in-network steering to prevent the merged hospitals from charging above-market rates!

**[8]** Another, less fundamental flaw in the courts’ “in-network-steering” rationale is that, at the very least, a sole source hospital will be able to successfully demand a price that is above the market level by the substantial amount it would cost a health plan to employ in-network steering.

**[9]** That physician who is near the patient’s workplace (or a colleague) may later admit that patient to the hospital near the physician’s office. That may explain much of the data about patients who were treated at a full service hospital other than the one near their home.

**[10]** Health plans allow enrollees to use the nearest hospital in a serious emergency – but not necessarily for an illness or injury that is not threatening to life or limb.

**[11]** *Vistnes & Sarafidis*, note 5 above.

**[12]** *See generally*, Kenneth Davis, *and cf.* Marty Markaray, note 3 above.

**[13]** Such a JOA is subject to Sherman Act Section 1. *See*: Mark J. Botti, *Comments on the Antitrust Aspects of Hospital Virtual Mergers* (DOJ Antitrust Division Speeches, 1998).

**[14]** *See*, e.g., Anna Wilde Mathews, *Anthem Effort to Cut Health Costs Sees Strong Start*, April 29, 2015 WSJ, p.B3. That is likely to involve an agreement between a health plan and a large medical practice whose member-physicians have overlapping privileges at multiple hospitals, or a “physician contracting organization” that has member-physicians at multiple hospitals.

**[15]** The trend toward vertical integration of hospitals and their medical staffs eliminates this important competitive mechanism, but the antitrust agencies have not challenged any of those transactions. (The FTC’s 2015 *St. Luke’s* decision does not address this issue.)