



**AAI's Series on Competition in the Delivery
and Payment of Healthcare Services**

**PART II
PROMOTING COMPETITION IN HEALTHCARE ENFORCEMENT AND
POLICY: FRAMING AN ACTIVE COMPETITION AGENDA**

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I. Introduction

The policy community, albeit belatedly, now fully recognizes the economic dangers of highly concentrated healthcare markets.² The Federal Trade Commission (FTC) and states continue to closely scrutinize hospital mergers. Recent successes by the U.S. Department of Justice (DOJ) in challenging mergers of health insurers are additional indications of invigorated enforcement in the healthcare payment sector. In addition, the FTC, DOJ, and State Attorneys General (AGs) have appropriately dedicated substantial resources to healthcare antitrust enforcement and have achieved significant victories in litigation.

Traditional merger review, however, will be inadequate to compensate for the policy failures of the past. In large part because failed antitrust interventions, overwhelmed enforcers, or mistaken beliefs that market dynamics or negotiated settlements will preserve market competition, both provider and insurer markets across the country are highly concentrated, and dominant providers currently enjoy enormous pricing power. To create the market dynamics that consumers desire, policymakers will need to pursue proactive approaches in healthcare markets that confront extant market power and aim to limit its damage. It will also require exploring innovative paths to stimulate lost or impeded competition. Over the past several years, the FTC has enhanced its advisory and advocacy efforts on healthcare

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² See Clark C. Havighurst & Barak Richman, *The Provider-Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 874 (2011); Avik Roy, *Hospital Monopolies: The Biggest Driver of Health Costs that Nobody Talks About*, FORBES (Aug. 22, 2011), <http://www.forbes.com/sites/theapothecary/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about/>.

competition issues in numerous forums, and its leadership will need to continue exploring its influence outside its traditional purview.

Antitrust policy, like many other policy areas, will have to be farsighted and proactive to maintain and enhance sorely needed competition in healthcare markets. While traditional antitrust measures can prevent the agglomeration of additional harmful market power, less traditional and more creative policies are necessary to police the harmful market power many healthcare entities have already amassed. Federal and state entities should therefore pursue an active competition agenda by deploying sufficient resources to both prevent the consummation of additional anticompetitive consolidation that enhances or entrenches monopoly power and to pursue multipronged policies to facilitate efficient, competitive markets in healthcare markets. These issues are complicated by the healthcare sector's long history of state and federal regulatory interventions that impede rivalry, discourage entry and innovation, and advance professional and corporate interests over those of consumers, but they also present multiple opportunities to correct problematic policies and inject competition into previously insulated markets.

In addition, responsibilities and opportunities to promote pro-competition policies must stretch beyond traditional antitrust enforcers, as regulators across government have the capacity to promote competition in healthcare markets. Close attention to regulatory interventions is also important because the distinction between public and private healthcare is vanishing. Government-financed health services, including Medicare and Medicaid, are increasingly relying on privately managed care to provide services. Without robustly competitive markets, these changes will not achieve the goals of controlling costs and improving quality. Likewise, proposals to replace Medicare's guaranteed benefits with premium support payments, block grant Medicaid, or force downward budgetary pressures on national healthcare spending are also highly dependent on competition between providers and between insurers.

Part I of the AAI White Paper series *Competition in the Delivery and Payment of Healthcare Services* provided an in-depth examination of the competition concerns and priorities in provider and insurer consolidation—both horizontal and vertical—that is sweeping the industry. Part II of the AAI White Paper Series advances the discussion to identify and define the policy responses needed to address extant market power and prospective issues raised by consolidated markets. These issues include employing antitrust and other measures to stem monopolistic provider practices, encouraging federal agencies to advocate in correcting anticompetitive state policies, and seeking alternative strategies to promote competition in healthcare provider and payer markets. We emphasize a growing need for advocacy in state policymaking, payment reform, and transparency, including issues such as scrutiny of state medical boards, state efforts to improve price and quality transparency, and encouraging precompetitive policies at the Center for Medicare & Medicaid Services (CMS). The final section concludes with policy recommendations.

II. Antitrust Actions and Regulatory Alternatives

COPA laws are problematic on a variety of grounds. The list of factors to be considered are frequently numerous, conflicting, and not subject to empirical analysis or measurement. Beyond the sheer volume of information necessary to address such complex policy

considerations, weighing them against competitive harm is an intractable task. The statutory formulae require that regulators evaluate and weigh incommensurables without guidance as to priorities or standards of proof. Even if standards can be accurately measured and weighed, political and practical problems abound.

A. Unbundling of Monopolized Services

One proactive remedial approach to hospital mergers is requiring unbundling of monopolized services. Problematic mergers often involve hospitals with a dominant position in their markets (so-called “must have” hospitals) that, as noted above, are a major driver of cost in healthcare.³ Economic studies demonstrate that the bargaining leverage these hospitals possess enables them to obtain reimbursement at levels not explained by quality, demographic, patient mix, or other factors.⁴

One reason dominant hospitals have been able to charge supracompetitive prices is because many offer sophisticated services unavailable at rival hospitals. They then leverage these services to extract revenues from other offered services that have competitive substitutes in the marketplace, thereby denying patients the benefits of competition and foreclosing entry by providers that could offer a more limited menu of services. Bundling has certain benefits, as bundled services for unified payments can increase efficiency and reduce costs associated with providing closely intertwined services.

However, the anticompetitive consequences of bundling monopolized and unmonopolized services are real and can include the squeezing out of rivals in the competitive market, the creation of another monopoly, and the limiting of entrants’ ability to challenge its hold on the monopolized market. The magnified consequences of healthcare monopolies should heighten concern over practices that can expand or enshrine provider monopolists.

Despite widespread bundling of hospital services and the collective dominance the practice enables, there have been few tying challenges to dominant providers. California very recently filed suit against a dominant health system, alleging illegal bundling and related anticompetitive monopolistic conduct.⁵ This suit could signify a new tactic limiting hospital monopolies. Hospitals’ bundled services offer a prime candidate for a reinvigorated anti-tying policy, and challenging such tying practices could open up meaningful competition in a host of ancillary markets.

One promising approach could be to require hospitals and other provider entities to unbundle, at a purchaser’s request, certain services so that the purchaser can negotiate prices.⁶ A workable rule would permit antitrust law to empower a purchaser to demand

³ See Off. of Mass. Att’y Gen. Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 61/2(b)* (Mar. 16, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>; Claudia H. Williams, et al., *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON FOUND. (2006), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

⁴ *Id.*; see also Robert Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggest Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012); Roy, *supra* note 2.

⁵ *California v. Sutter Health*, No. CGC-18-565398 (S.F. Super. Ct. filed Mar. 29, 2018).

⁶ Havighurst & Richman, *supra* note 2, at 876.

separate prices for divisible services that are normally bundled.⁷ The hope would be that antitrust courts and a credible threat of treble damages would discourage a provider monopolist from retaliating against any purchaser that aggressively challenges its anticompetitive practices. Indeed, the costs and delays from such complex antitrust actions suggest that public enforcement should supplement private suits. Either regulators could enable individual payers to demand unbundling to facilitate their efforts to get better prices or regulators could demand it themselves. This could trigger more competition and greater efficiency in both the tying submarkets where monopoly is not a problem and the tying markets where it is.

B. Challenging Anticompetitive Terms in Insurer-Provider Contracts

Another source of competitive harm is found in restrictive terms in contracts between providers and insurers. Many agreements between dominant providers and dominant insurers contain provisions that serve to enshrine each party's leadership in their respective markets. They therefore foreclose competition in both healthcare markets, and they offer another potentially fruitful area for antitrust and regulatory attention in dealing with the provider monopoly problem.⁸

A common practice, for example, is for a provider-seller to promise to give an insurer-buyer the same discount from its high prices it might give to a competing health plan. Such price-protection, payment parity, or most-favored-nation (MFN) clauses are common in commercial contracts and reduce frequent and costly renegotiation of prices. However, their anticompetitive effects can outweigh their efficiencies. Thus, a provider monopolist may find that a large and important payer is willing to pay its very high prices only if the provider promises not to charge lower prices to its competitors. Such a situation arose in Massachusetts, where the commonwealth's largest insurer, a BlueCross plan, reportedly acceded to Partners HealthCare's demand for a very substantial price increase only after Partners agreed to "protect Blue Cross from [its] biggest fear: that Partners would allow other insurers to pay less."⁹

Antitrust law can offer relief against a provider monopolist that secures its high prices through an MFN clause with a powerful insurer. Because such clauses protect insurers against their competitors' getting better deals, many insurers are likely to give in too quickly

⁷ Antitrust Modernization Comm'n, *Report and Recommendations* 96 (2007), available at http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf (this proposal is in line with the recommendations of the report). What is "divisible" in health care is of course subject to debate, just as most services accused of being bundled are often defended as a single product. See e.g., *Jefferson Parish Hosp. Dist. No. 2. v. Hyde*, 466 U.S. 2, 19-22 (1984).

⁸ See Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions*, AM. ENTER. INST. (2012), http://www.aei.org/wp-content/uploads/2012/06/-concentration-in-health-care-markets-chronic-problems-and-better-solutions_171350288300.pdf.

⁹ Scott Allen & Marcella Bombardieri, *A Handshake That Made Healthcare History*, BOS. GLOBE (Dec. 28, 2008), <https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8oJJsA3IZ11o1H/story.html>; see also Coakley, *supra* note 3, at 40-41 (noting that such payment-parity agreements have become "pervasive" in provider-insurer contracts in the commonwealth and expressing concern that "such agreements may lock in payment levels and prevent innovation and competition based on pricing").

to even extortionate monopolist price demands. But the availability of an antitrust remedy (which would likely be a prospective cease-and-desist order rather than an award of treble damages for identifiable harms) might not be sufficient to deter a powerful provider from granting MFN status to a dominant insurer. Antitrust case law involving MFNs is mixed. A number of older cases refused to find MFN contracts deployed by dominant insurers as anticompetitive¹⁰ while other cases treat them with greater skepticism.¹¹

More recently, a court in Michigan sustained the DOJ's challenge to the MFNs imposed by Blue Cross and Blue Shield of Michigan finding allegations that the MFNs increased insurance premiums as well as the costs of competitors were sufficient to avoid dismissal.¹² Another noteworthy aspect of the Michigan case is the court's rejection of a state action defense.¹³ While no court has yet struck down MFN under the antitrust law, several private treble damage actions are pending.

An alternative, and perhaps more efficient, way to attack MFNs is through legislation or regulation. The Michigan case was dismissed after the Michigan legislature passed a law banning insurer MFNs, and at least sixteen other states have done so.¹⁴ Likewise, regulatory authorities could prohibit dominant providers from conferring such status. Regulators presumably would be in as good a position as any party to distinguish between restrictive agreements that achieve transactional efficiencies and agreements that restrict insurers' freedom to cut price deals with competitors. Regulators might also be sensitive to how MFN clauses can reduce pressure on, and opportunities for, all insurers to seek new and innovative service arrangements.

Other contract provisions that threaten price competition are also in use in provider-insurer contracts in several states.¹⁵ In particular, so-called "anti-tiering" or "anti-steering" provisions prohibit an insurer from creating insurance products in which patients are induced to patronize lower-priced providers. Under such a contractual constraint, a health plan could not offer more generous coverage—such as reduced cost sharing—for care obtained from a new market entrant or from a more distant, perhaps even an out-of-state or out-of-country, provider.

The DOJ and the State of North Carolina have challenged one such practice, asserting that a health system exercised its market power by insisting on contract terms that prevented major

¹⁰ See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989) (finding MFN not predatory under Section 2 of Sherman Act); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1415 (1st Cir. 1989) (describing MFNs as "standard devices by which buyers try to bargain for low prices" and "the sort of conduct that the antitrust laws seek to encourage").

¹¹ See e.g., *United States v. Delta Dental*, 943 F. Supp. 172 (D.R.I. 1996) (denying defendant's motion to dismiss government's challenge to insurer's MFN under Section 1 of the Sherman Act).

¹² *United States v. Blue Cross Blue Shield of Mich.*, 809 F. Supp. 2d 665 (E.D. Mich. 2011).

¹³ *Id.* at 676-78 (finding that nothing in Michigan law endorses MFNs or requires administrative oversight).

¹⁴ Erin C. Fuse Brown, *State Strategies to Address Rising Prices Caused by Health Care Consolidations*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Sept. 2017), <https://nashp.org/wp-content/uploads/2017/09/Consolidation-Report.pdf>.

¹⁵ Coakley, *supra* note 3 at 40-44.

insurers from steering patients to lower-cost hospitals.¹⁶ The anticompetitive harm from such restrictions are of particular concern because payers need mechanisms such as offering tiered networks to induce dominant providers to bargain over price. Again, a legislative or regulatory solution may be advisable. Massachusetts, for example, has banned anti-tiering and anti-steering laws,¹⁷ while another option would be for state insurance regulators to reject proposed policies containing such provisions.¹⁸

The contractual terms noted here all enshrine the cooperative supremacy of dominant providers and dominant insurers. The resulting competitive harm extends beyond the sustenance of high prices. These partnerships also foreclose opportunities for consumers to benefit, both directly as patients and indirectly as premium payers, from innovative insurance products that competing health plans might otherwise introduce. Antitrust rules can prohibit the use of such anticompetitive contract terms to protect provider monopolies and curb insurer innovation. Insurance regulators might also bar such provisions wherever they threaten to preclude effective price competition. These actions remain available even in the continued presence of a provider monopoly.

C. Promote Provider and Insurer Entry

Another tactic for dealing with the dominant hospital problem is to facilitate competitive entry. The principal potential source of competition to dominant acute care hospitals are facilities controlled by physicians. These facilities (also referred to as “carve-out” or “boutique” hospitals) are hospitals that provide care for a limited range of conditions or perform only specified procedures.¹⁹ The rapid growth of such facilities, which typically specialized in a service such as heart care or orthopedics, was slowed considerably by provisions of the Affordable Care Act (ACA) that responded to concerns that these hospitals were cherry picking healthy and affluent patients.

Nevertheless, with physicians participating directly in integrating care through accountable care organizations (ACOs), it is possible (and desirable) that restrictions on physician ownership be eased subject to controlling the problems identified in the past. Moreover, as health services continue to migrate from inpatient to outpatient settings, including outpatient surgery centers, retail clinics and urgent care facilities, physicians are well positioned to offer alternatives to the traditional inpatient acute care facility. States should examine reducing impediments to the growth of these facilities that result from overly restrictive rules regarding facility licensure, certificate of need (CON), and conditions of participation.²⁰

¹⁶ *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720, 730 (W.D.N.C. 2017) (finding the claim “raised serious and robust questions about the purposes, effects and legality of its contractual steering restrictions and steering restrictions generally”).

¹⁷ MASS. GEN LAWS ANN. ch. 176O, § 9A.

¹⁸ See Martin Gaynor et al., *Making Health Care Markets Work: Competition Policy for Health Care*, 317 JAMA 1313 (2017) (recommending that insurance commissioners with powers to review insurance contractual terms reject those containing anti-steering/tiering clauses and those lacking such authority refer matters to state attorneys general or seek legislative authority).

¹⁹ See U.S. Gov’t Accountability Office, GAO-04-167, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance* (2003).

²⁰ See Nat’l Acad. Soc. Ins., *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets* 29 (2015), https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf.

However, hospitals' employment of physician rivals has been associated with avoiding competition, especially where there are significant barriers to entry.²¹ Under these circumstances, allowing hospitals to preempt potential rivals constitutes an unwise turn in competition policy. Finally, the expansion of healthcare facilities, clinics and networks depends on the availability of professionals to staff them. As discussed *infra*, expanding the supply of complementary healthcare providers and permitting them to practice to the full extent of their license is a closely related policy objective.

The insurance exchanges set up by the ACA also offer an opportunity to encourage entry into the generally concentrated insurance market. Exchanges offer a platform for effective price and quality comparisons across insurance products, thus removing many of the historical upfront costs to marketing insurance plans or investing in insurance brokers. Indeed, where regulation can improve the functioning of markets by mitigating market imperfections--as the ACA does by standardizing insurance products and reducing search frictions.

To be sure, the ACA exchanges have encountered both political and logistical setbacks, and their future remains uncertain, but should they remain, rules governing network adequacy, actuarial thresholds, and the like should be viewed with an eye towards encouraging greater choice and competition across plans.

III. Promoting Competitive Healthcare Policy Beyond the Clayton and Sherman Acts: Advocacy in State Policymaking, Payment Reform, and Transparency

Ensuring competitive healthcare markets relies on active policymaking beyond the traditional scope of the Sherman Act, and federal antitrust policymakers should seek opportunities to promote competition-enhancing policies outside their roles of policing monopolistic conduct, mergers, or cartel behavior.

A. Advocacy in State Policymaking

An enormous amount of healthcare policy is made at the state level, and many policy decisions now confronting state legislatures have significant implications for competition in healthcare markets. The Agencies should invest heavily in monitoring and advising state regulators regarding potential harms to competition arising from various state regulations and policies. The FTC, in issuing the policy perspective "Competition and the Regulation of Nurses"²² and in testifying before Congress on "Competition and the Potential Costs and

²¹ See Lawton R. Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375, 388-89 (2008) (listing as incentives to employ physicians, hospitals' desire to "keep physicians (particularly specialists) from directly competing with hospital service lines [and] neutralize the threat of niche providers, preempt their market entry, and prevent the loss of outpatient share").

²² *Policy Perspectives: Competition and Regulation of Advanced Practice Nurses*, FED. TRADE COMM'N (Mar. 2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolycypaper.pdf>.

Benefits of Professional Licensure²³ has offered fruitful guidance to state policymakers in identifying costly state-based regulations that impose anticompetitive harm on healthcare consumers. We encourage the agencies to continue playing this role of policy advocate, paying heed to these and other policy areas.

1. State Licensure and Scope of Practice Laws

As the FTC report and testimony cited above reflect, professional licensure and scope of practice constraints impose unnecessary costs and limit competition in healthcare markets. In particular, restrictive scope-of-practice regulations for Advanced Practice Registered Nurses (APRNs) have been found to reduce access and quality and increase costs. For example, a 2011 Institute of Medicine (IOM) report recommended that states reform scope-of-practice regulations and provide for direct Nurse Practitioner (NP) reimbursement in order to allow nurses to help meet the growing primary care shortage.²⁴

Moreover, the National Governors Association has reported that nurse practitioners have been shown to provide comparable quality care as physicians and recommended that states consider easing scope-of-practice restrictions and modifying reimbursement policies to encourage greater NP involvement in primary care.²⁵ For these reasons, twenty-two states and the District of Columbia have granted nurse practitioners expanded practice authority, with seven states liberalizing APRN scope-of-practice regulations in the last five years.²⁶ Other states are now considering their own reform proposals.²⁷

The Agencies should engage in this policy debate and advocate on behalf of liberalizing state licensure and scope-of-practice limitations. States that have liberalized their rules have partaken in the benefits of more competitive markets, finding that less restrictive APRN regulations generate greater access to APRNs²⁸ and lower healthcare costs,²⁹ and additional

²³ Prepared Statement, Fed. Trade Comm'n, *Competition and the Potential Costs and Benefits of Professional Licensure Before the Committee on Small Business United States House of Representatives*, 9-16 (2014), https://www.ftc.gov/system/files/documents/public_statements/568171/140716professionallicensurehouse.pdf.

²⁴ Inst. of Medicine, *The Future of Nursing Leading Change, Advancing Health*, NAT'L ACADEMIES PRESS (2011).

²⁵ See Maria Schiff, *The Role of Nurse Practitioners in Meeting Increasing Demand For Primary Care*, NAT'L GOVERNORS ASS'N 1, 8 (Dec. 20, 2012), <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>.

²⁶ See e.g., Certified Nurse Practitioners – Authority to Practice, 2015 Md. Laws ch. 468; *State Practice Environment*, AM. ASS'N NURSE PRAC., <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment> (last visited June 11, 2018).

²⁷ See, e.g., Sam Kennedy, *Pa. Bill Would Let Nurse Practitioners Work Without Doctors*, THE MORNING CALL (Mar. 28, 2015), <http://www.mcall.com/news/nationworld/pennsylvania/mc-pa-nurse-practitioners-20150328-story.html>; Anna Bamonte Torrance, *Pennsylvania Senate Bill Proposes Independent Practice of Certified Nurse Practitioners*, W. PA. HEALTHCARE NEWS (May 14, 2014), <https://www.wpahealthcarenews.com/category/legal/page/2/>.

²⁸ Patricia Reagan & Pamela Salsberry, *The Effects of State-Level Scope-of-Practice Regulations on the Number and Growth of Nurse Practitioners*, 61 NURSING OUTLOOK 392 (2013). At least two other studies have used the study to project increases over time for an individual state. See Christopher J. Conover et al., *Economic Benefits of Less Restrictive Regulation of Advanced Practice Nurses in North Carolina*, 63 NURSING OUTLOOK 585 (2015) (applying the Reagan and Salsberry study to North Carolina and projecting hypothetical increases for year 2012); Micah Weinberg & Patrick Kallerman, *Full Practice Authority for Nurse Practitioners Increases Access and Controls Cost*, BAY AREA COUNCIL ECON. INST. (2014), [8](https://campaignforaction.org/wp-content/uploads/2016/03/BACEI-</p></div><div data-bbox=)

evidence suggests that better healthcare quality is associated with greater access to APRNs.³⁰ Given the evidence of competitive benefits associated with these reform efforts, the Agencies should contribute to state-based reform efforts as more state legislatures consider liberalizing APRN scope-of-practice rules. The Agencies similarly might promote additional liberalization efforts for regulations that currently constrain other low-cost healthcare providers.

2. Certificate of Need and Certificate of Public Advantage Laws

Certificate of Need laws have long been an object of frustration for policymaker and commentators who advocate for competitive healthcare markets.³¹ Currently, 36 states and the District of Columbia continue to maintain some form of a CON regime that puts constraints on when providers can expand, enter, provide new services, or introduce new equipment in healthcare markets.³² Among the many problems with these laws is the lack of clarity and the resulting untethered discretion given to politically appointed boards. For example, many statutes contain a “kitchen sink” approach, identifying as many as a dozen criteria to be applied.³³

NP-Report-9.8.14.pdf (applying the Reagan and Salsberry study to California and projecting hypothetical increases for year 2011).

²⁹ Christine E. Eibner et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, 103 RAND HEALTH (2009), www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.pdf; PERRYMAN GRP., *The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in Texas: An Analysis of Local and Statewide Effects on Business Activity* 13 (May 2012), http://c.ymcdn.com/sites/flanp.site-ym.com/resource/resmgr/articles_and_research/Perryman-APRN-Utilization-E.pdf.

³⁰ Richard S. Hooker et al., *Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries*, 12 J. CLINICAL OUTCOMES MGMT. 88, 91 (2005); Bryant Furlow, *Nurse Practitioners Outscore Physicians in Patient Satisfaction Survey*, CLINICAL ADVISOR (Jun. 24, 2011), <http://www.clinicaladvisor.com/nurse-practitioners-outscore-physicians-in-patient-satisfaction-survey/article/206090/> (“For 15 of 18 core questions, the difference was statistically significant, all in favor of NPs[.]”); see also P. Venning et al., *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320 BRIT. MED. J. 1048, 1053 (2000); Miranda G. H. Laurant et al., *An Overview of Patients’ Preference for, and Satisfaction with, Care Provided by General Practitioners and Nurse Practitioners*, 17 J. CLINICAL NURSING 2690 (2008); A. Guzik et al., *Patient Satisfaction with NP and Physician Services in the Occupational Health Setting*, 57 AM. ASSOC. OF OCCUPATIONAL HEALTH NURSES J. 191 (2009); D. Litaker et al., *Physician-Nurse Practitioner Teams in Chronic Disease Management: The Impact on Costs, Clinical Effectiveness, and Patients’ Perception of Care*, 17 J. INTERPROFESSIONAL CARE 223 (2003); A. T. Dierick-van Daele et al., *Nurse Practitioners Substituting for General Practitioners: Randomized Controlled Trial*, 65 J. ADVANCED NURSING 391 (2009). For an excellent survey, see also Kyle Jaep & John Bailey, *The Value of Full Practice Authority for Pennsylvania’s Nurse Practitioners*, DUKE L. NEWS (2015), https://law.duke.edu/news/pdf/nurse_practitioners_report-PA-TechnicalAppendix.pdf.

³¹ For an early and prescient critique of Certificate of Need regulations, see Clark C. Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need”*, 59 VA. L. REV. 1143 (1973), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1358&context=faculty_scholarship.

³² Thomas Stratmann et al., *Certificate-Of-Need Laws: How CON Laws Affect Spending, Access, and Quality Across the States*, MERCATUS CTR. (Aug. 29, 2017), <https://www.mercatus.org/conlaws>; see also Koopmand & Ann Philpot, *The State of Certificate-of-Need Laws in 2016*, MERCATUS CTR. (Sept. 27, 2016), <https://www.mercatus.org/publications/state-certificate-need-laws-2016>.

³³ See BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 979-81 (7th ed. 2013).

Early studies of CON regulations found that the constraints did little to constrain healthcare spending³⁴ and even did little to constrain hospital investments.³⁵ More recent studies have concluded that mature CON programs are associated with a modest reduction in acute care spending per capita but not a significant reduction in total per capita spending, with a slight reduction in bed supply but higher costs per day and per admission, along with higher hospital profits.³⁶ Perhaps the biggest cost to CON regulations is its role in solidifying the delivery system, both in its stifling of new entrants and in its constraints on introducing alternative strategies.

Several states are now considering repealing their CON regulations.³⁷ We encourage the agencies, just as the FTC has done in the debate over APRN scope-of-practice regulation, to examine the costs of CON regulations and to issue advocacy reports that can guide state policymakers. Where repeal is not feasible, states should consider clarifying the standards to be applied and explicitly requiring consideration of the competitive impact of CON determinations.

As discussed in Part 1 of this Series, state Certificate of Public Advantage Laws have the potential to encourage anticompetitive mergers. These laws are problematic on a variety of grounds. The list of factors to be considered are frequently numerous, conflicting, and not subject to empirical analysis or measurement. Beyond the sheer volume of information necessary to address such complex policy considerations, weighing them against competitive harm is an intractable task. The statutory formulae require that regulators evaluate and weigh incommensurables without guidance as to priorities or standards of proof. Even if standards can be accurately measured and weighed, political and practical problems abound. It is nonetheless apparent that COPAs are viewed by some as a way of “getting your merger through.”³⁸ Therefore we support the FTC’s proposed study of the effects of these laws³⁹ and urged continued advocacy at the state level to discourage their implementation.

³⁴ Frank Sloan & Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 J. L. & ECON. 81 (1980); Paul L. Joskow, *The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital*, 11 BELL J. ECON. 421 (1980); Paul L. Joskow & Roger C. Noll, *Regulation in Theory and Practice: An Overview*, in *Studies in Public Utility Regulation*, MIT PRESS (Gary Fromm ed., 1981).

³⁵ Fred Hellinger, *The Effect of Certificate-of-Need Legislation on Hospital Investment*, 13 INQUIRY 187 (1976); David Salkever & Thomas Bice, *The Impact of Certificate-of-Need Controls on Hospital Investment*, 54 MILBANK MEMORIAL FUND Q. 185 (1976).

³⁶ Christopher Conover & Frank Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL’Y & L. 455, 458 (1998).

³⁷ See Mark Taylor, *States Scrutinizing Certificate of Need Programs*, HEALTHCARE FIN. MGMT. ASS’N (Feb. 18, 2017), <https://www.hfma.org/Content.aspx?id=52833>; Matthew Glans, *Research & Commentary: North Carolina Certificate of Need Repeal*, THE HEARTLAND INST. (Apr. 22, 2015), <https://www.heartland.org/publications-resources/publications/research--commentary-north-carolina-certificate-of-need-repeal>; Zack Budryk, *The Pros and Cons of Certificate of Need Repeal*, FIERCEHEALTHCARE (Jul. 13, 2015), <https://www.fiercehealthcare.com/finance/pros-and-cons-certificate-need-repeal>.

³⁸ Alexis J. Gilman & Alexis Victoria DeBernardis, *COPAs: A Way Around Federal Antitrust Enforcement to Get Your Hospital Merger Through?*, AHLA CONNECTIONS (May, 2018).

³⁹ Press Release, Fed. Trade Comm’n, *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments* (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/p181200_copa_assessment_comment_notice_11-1-17.pdf?utm_source=govdelivery.

3. Insurance Regulation

Health insurance is a heavily regulated industry. At the same time the nation depends on robust competition among insurers and among providers to promote consumer welfare. For example, the ACA created a new framework for the delivery and purchase of health insurance by establishing state exchanges (or “marketplaces”) to facilitate the sale of insurance products in the individual and small group market. The degree of competition largely hangs on the degree of competition encouraged by these exchanges. The regulation of these exchanges, therefore, will significantly determine the success of the ACA and its ability to bring affordable health insurance to consumers in the individual and small business markets. Likewise, the market for insurance and administrative services for large employers and beneficiaries of government programs such as Medicare Advantage and Medicaid Managed plan requires regulation that supports and does not undermine competition.

While the McCarran Ferguson Act and longstanding policy has vested primary regulation of insurance in the states, in some instances, state laws may operate at cross-purposes with the broader objectives of competitive policy. For example, excessive restrictions on the composition of payor networks under so-called “network adequacy laws” can impair the ability of payors to bargain effectively on price and quality with providers.⁴⁰ As such they may restrict the availability of narrow network plans, which have had some success constraining costs and therefore can be offered at lower prices. We recommend that states adopt a nuanced approach, as recommended by Professors Hall and Ginsburg that avoids the risk of over-regulation and standardless delegation of authority.⁴¹

Another group of state laws, generally referred to as “any willing provider laws,” may also serve to undermine competition. These laws typically provide that insurers must include in their networks any provider that is qualified to practice in their locale. The effect of AWP laws is to inhibit the ability of insurers to bargain and contract selectively in forming their provider networks. As a result, some studies show that they increase costs.⁴²

The Agencies could play productive roles in helping fine tune the regulations governing the state insurance exchanges. The health insurance market has always needed regulatory supervision, but excessive regulation could undermine the viability of state insurance markets. We encourage the Agencies to monitor the development of these exchanges and encourage the promotion of pro-competitive regulatory strategies.

⁴⁰ See Mark A. Hall & Paul B. Ginsburg, *A Better Approach to Regulating Network Adequacy*, BROOKINGS INST. (Sept. 14, 2017), <https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/>.

⁴¹ *Id.* at 22-24.

⁴² Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of “Any-Willing-Provider” Regulations*, 20 J. HEALTH ECON. 955 (2001); Len M. Nichols, *Déjà vu? The Debate Over Any Willing Provider Laws May Return, Sad to Say*, CTR. FOR HEALTH POL’Y RES. & ETHICS, GEO. MASON UNIV. (Sept. 19, 2014), <https://chpre.org/wp-content/uploads/2015/05/CHPRE-Issue-Brief-2.pdf>.

B. Expanding Scrutiny of State Medical Boards and Other Professional Bodies

The FTC earned an enormously valuable victory when the Supreme Court, in *North Carolina Board of Dental Examiners v. Federal Trade Commission*,⁴³ subjected unsupervised state medical and professional boards controlled by private market participants to antitrust scrutiny. As these state professional boards have frequently been the driving force behind many anticompetitive regulations,⁴⁴ the new ruling creates an opportunity to enforce the antitrust laws where previously they were plausibly inapplicable. The antitrust agencies would make further headway in promoting competitive healthcare markets by capitalizing on this victory and scrutinizing the rules and restrictions imparted by these boards.

One particular dispute in Texas illustrated with stark clarity the capacity of state boards to produce anticompetitive regulations. In large response to the growth of Teledoc, a successful provider of telemedicine services, the state medical board issued rules requiring certain in-person visits before administering certain forms of healthcare.⁴⁵ The rules were widely perceived as an attack on telemedicine by the traditional providers represented on the state board, and Teledoc promptly sued the medical board under the Sherman Act.⁴⁶

The rise of new uses of technology, and their challenge to the traditional delivery of medicine, will likely increase disputes between state medical boards and innovative providers, and they similarly may lead to more antitrust lawsuits. We encourage the FTC to monitor and interject accordingly in both current and emerging disputes between state medical boards and firms offering telemedicine services. We further encourage the FTC to consider developing guidance to medical boards—and any potential supervising state officials—on policies that will trigger antitrust scrutiny.

Although the state medical board eventually revised its rules, thus leading to a joint dismissal of Teledoc's antitrust suit, the retreat did not happen until after the board claimed Parker Immunity. Because medical boards controlled by private market participants are immune from antitrust scrutiny if they act pursuant to a clearly articulated state policy and are actively supervised by state officials,⁴⁷ the Texas board's claim of immunity was a common move following the issuance of regulations that inhibit innovations and entrants. Accordingly, the contours of Parker Immunity, especially in light of *North Carolina Board of Dental Examiners*, will meaningfully shape the scope of competition among alternative providers, and many

⁴³ *N.C. Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1117 (2015) (“The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.”)

⁴⁴ Clark C. Havighurst, *Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and Health Care Markets*, 31 J. HEALTH POL. POL'Y & L. 587 (2006).

⁴⁵ *Teladoc, Inc. v. Tex. Med. Bd.*, 453 S.W.3d 606 (Tex. App. Austin, 2014); Abby Goodnough, *Texas Medical Panel Votes to Limit Telemedicine Practices in State*, N.Y. TIMES (Apr. 10, 2015), http://www.nytimes.com/2015/04/11/us/texas-medical-panel-votes-to-limit-telemedicine-practices-in-state.html?_r=0.

⁴⁶ Katie Dvorak, *Court Ruling Spells Possible Victory for Teladoc Against Texas Medical Board*, FIERCEHEALTHCARE (June 1, 2015), <http://www.fiercehealthit.com/story/court-ruling-spells-possible-victory-teladoc-against-texas-medical-board/2015-06-01>.

⁴⁷ See *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 99 (1980).

states have thus asked the FTC for guidance on how they may satisfy Midcal's twin requirements. The FTC released a guidance document in October 2015,⁴⁸ although tensions between the traditionalism of medical boards and the demands for innovative and lower-cost delivery pathways will sustain uncertainty and scrutiny in this area of law.

We recommend that the FTC continue to remind policymakers of the sober reality that boards dominated by market participants are prone to produce anticompetitive regulations. Moreover, the FTC should consider taking a proactive role in helping states craft regimes in which medical boards do not have inappropriate leeway without active state supervision. It is also worthwhile to examine how different states have constructed regimes around professional medical boards and assess whether structural differences influence the competitiveness of the subsequent regulations. For example, California has constructed a regime very different from the one in North Carolina that failed the active supervision test.

First, one third of the members of California's medical, dental, nursing, and other healing arts professional boards are appointed by either the governor or legislature, and these "public members" are tasked with pursuing the public interest and instituting some political accountability into the boards' actions.⁴⁹ In contrast, all the members of North Carolina's dental board, like those of most other professional boards, are either elected by or appointed after input from the professional association. And second, California law institutes several checks to the state boards' actions, including empowering the state's Department of Consumer Affairs to review and investigate any board action⁵⁰ and tasking the state's Office of Administrative Law to review all professional board regulations.⁵¹

Because many important healthcare policy decisions are made by these state professional boards, and the structure of these boards often creates incentives to produce anticompetitive regulations, we encourage the FTC to continue monitoring health professional boards' conduct. And because many states are considering how to revise their regulatory regime in response to the Supreme Court's recent ruling, we encourage the FTC to monitor and guide

⁴⁸ *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*, FED. TRADE COMM'N (Oct. 14, 2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf. Commissioner Maureen Ohlhausen additionally shed some light on the potential guidelines, highlighting three major changes state boards should consider implementing: avoiding decisions that could hinder competition, constructing boards such that the majority of its members are not active market participants, and ensuring that the state actively supervises the board. See Lisa Schnecker, *FTC Commissioner Suggests Regulatory Board Changes Following Supreme Court Decision*, MODERNHEALTHCARE (Apr. 1, 2015), <http://www.modernhealthcare.com/article/20150401/NEWS/150409985/ftc-commissioner-suggests-regulatory-board-changes-following-supreme>; Maureen K. Ohlhausen, Comm'r U.S. Fed. Trade Comm'n, *Reflections on the Supreme Court's North Carolina Dental Decision and the FTC's Campaign to Rein in State Action Immunity*, HERITAGE FOUNDATION (Mar. 31, 2015), https://www.ftc.gov/system/files/documents/public_statements/634091/150403hertiagedental.pdf.

⁴⁹ Public members on California boards have been credited with swiftly ending certain anticompetitive practices. For example, public members on the California Dental Board uncovered a range of professional-protective practices, including a discriminatory scoring system on licensing exams to screen out candidates and testing of outdated dental techniques (which were long phased out of medical education outside of California) to handicap out-of-state licensure applicants. See Kurt W. Melchior & Richard B. Spohn, *This isn't North Carolina, Toto: California Boards Should Survive the Dental Board Case*, 109 ANTI-TRUST & TRADE REG. REPORT 148 (Aug. 1, 2015), http://www.nossaman.com/Files/47669_Bloomberg-BNA.pdf.

⁵⁰ CAL. BUS. & PROF. CODE §§ 151, 153, 155, 159.5.

⁵¹ CAL. GOV'T CODE § 13403(e).

how state policymakers implement mechanisms to actively supervise their professional boards. We additionally encourage state and federal reformers to seek legislative proposals, as several have, that establish more robust supervision regimes as a condition for receiving antitrust immunity. Such approaches might both satisfy the Supreme Court’s requirements under *Board of Dental Examiners* and ensure the political accountability that ostensibly would preclude anticompetitive conduct to take place. The FTC has appropriately taken a leadership role in shaping reform of this kind, and we additionally encourage legislators to adhere to its guidance.⁵²

C. Support State Efforts to Improve Price and Quality Transparency

The field of health economics was born in 1963, with the publication of “Uncertainty and the Welfare Economics of Medical Care”⁵³ by soon-to-be Nobel Laureate Kenneth Arrow. Arrow states his brilliant thesis succinctly: “the special economic problems of medical care can be explained as adaptations to the existence of uncertainty in the incidence of disease and in the efficacy of treatment.”⁵⁴ And, Arrow continues, “Where there is uncertainty, information or knowledge becomes a commodity. [I]nformation, in the form of skilled care, is precisely what is being bought from most physicians, and, indeed, from most professionals.”⁵⁵

Even though healthcare markets, healthcare delivery, and health economics have changed dramatically since 1963, Arrow’s foundational insight on the role of information remains true. Then, as now, uncertainty abounds in nearly every aspect of healthcare delivery, and information remains the cure to uncertainty. And one source of persistent uncertainty that has hindered the competitiveness of healthcare markets has been the lack of quality and price information made available to consumers. Since substantial evidence illustrates that consumers act swiftly and wisely when they do possess useful healthcare information,⁵⁶ healthcare and competition policymakers should collaborate to ensure that consumers have the information they need.

Currently, several government efforts in the U.S. aim to enhance price and quality transparency. CMS has launched the Hospital Inpatient Quality Program and Outpatient Quality Program, along with its Hospital Compare website, and numerous states have begun constructing All Payer Claims Databases (APCDs) that will inform citizens of the costs and quality exhibited by local providers. In fact, a growing number of states are taking active roles in promoting price transparency, with now more than nine states implementing public

⁵² See Randy M. Stutz, *State Occupational Licensing Reform and the Federal Antitrust Laws: Making Sense of the Post-Dental Examiners Landscape*, AM. ANTITRUST INST. (Nov. 6, 2017), <http://www.antitrustinstitute.org/content/aai-weighs-state-occupational-licensing-reform-debate>.

⁵³ Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

⁵⁴ *Id.* at 941.

⁵⁵ *Id.* at 946.

⁵⁶ Jonathan Ketcham & Jonathan Gruber, *Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, 101 AM. ECON. REV. 1180 (2011); Jonathan Ketcham, et al., *Paying Attention or Paying Too Much in Medicare Part D*, 105 AM. ECON. REV. 204 (2015).

APCDs that allow comparisons between the prices accepted by various providers across a range of payors.⁵⁷

To date, these U.S. efforts have not generated the data clarity that the other nations have achieved. The metrics used too often are imprecise,⁵⁸ track procedures rather than outcomes,⁵⁹ fail to distinguish high from low quality providers,⁶⁰ and are not accessible to the public or to consumer organizations that seek to offer informed recommendations.⁶¹ Nonetheless, these efforts remain at their nascent stages, and though they have yet to produce reliable information for consumers, they are an important development in healthcare policy. The Agencies should encourage and promote these efforts to bring greater transparency, and thus greater competition, to healthcare markets.

Private actors have also initiated projects to increase price transparency, targeting to reform opaque pricing mechanisms and to enable healthcare consumers to compare price and quality data across a range of providers. Third-party organizations, such as FAIR Health Consumer, are compiling healthcare price data and offering tools to consumers to compare price and quality metrics for certain providers,⁶² and businesses like Castlight Health, Inc., are offering similarly comprehensive comparison tools to employees of subscribing businesses.⁶³ In an effort to reduce their own costs, some insurers, like Blue Cross and Blue Shield of North Carolina, have similarly offered their members a database to compare provider prices.⁶⁴ These efforts also deserve support from the Agencies. Although some scrutiny on information sharing might be applicable, the Agencies should apply any such scrutiny with the understanding that these efforts are bringing some sorely needed transparency to a very opaque marketplace.

Similarly, the Agencies should be aware of certain legal obstacles and challenges to states' efforts to establish APCDs. In 2016, the Supreme Court ruled that a Vermont law to require private insurers to contribute data to its APCD was preempted by the Employee Retirement Income Security Act of 1974 (ERISA).⁶⁵ This unfortunate decision places a major obstacle

⁵⁷ See Jo Porter et al., *The Basics of All-Payer Claims Databases: A Primer for States*, ROBERT WOOD JOHNSON FOUND. (Jan. 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988.

⁵⁸ See Jonah J. Stulburg, et al., *Adherence to Surgical Care Improvement Project Measures and the Association with Postoperative Infections*, 303 JAMA 2479 (2010).

⁵⁹ See Mary T. Hawn et al., *Surgical Site Infection Prevention: Time to Move Beyond the Surgical Care Improvement Program*, 254 ANNALS OF SURGERY 494 (2011).

⁶⁰ See Safavi, K. C. et al., *Variation in Surgical Quality Measure Adherence within Hospital Referral Regions: Do Publicly Reported Surgical Quality Measures Distinguish among Hospitals That Patients are Likely to Compare?*, 49 HEALTH SERV. RES. 1108 (2014).

⁶¹ U.S. Gov't Accountability Office, GAO-15-11, *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers* (2014).

⁶² FAIR Health Consumer is a national independent, not-for-profit corporation whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products and consumer resources. See <https://www.fairhealthconsumer.org>.

⁶³ Castlight's Enterprise Healthcare Cloud technology enables employers to deliver world-class benefits to their people and empowers employees with the information they need to make better healthcare decisions for themselves and their families. See <http://www.castlighthealth.com/solutions/>.

⁶⁴ See Estimate Health Care Costs, BLUE CROSS & BLUE SHIELD OF N.C., <http://www.bcbsnc.com/content/providersearch/treatments/index.htm#/> (last accessed June 12, 2018) (providing calculation of your estimated cost for a medical treatment based upon your zipcode).

⁶⁵ *Gobeille v. Liberty Mut. Insurance Co.*, 136 S. Ct. 936 (2016).

for states wanting to improve competition by increasing price transparency.⁶⁶ The case illustrates both that ERISA poses some administrative barriers (though nothing that cannot be overcome) to certain transparency efforts, and also that legal challenges to policies promoting price and quality transparency are certain to come from dominant insurers, providers, and other actors who consider transparency to be a threat. Tellingly, six states that had or were developing APCDs filed an amici brief in support of Vermont, led by New York and including Maryland, Massachusetts, New Hampshire, Oregon, and Utah. Their brief reveals the challenging political and legal landscape in which transparency efforts are taking place:

The usefulness of an all-payer claims database comes principally from its comprehensiveness. If a large and distinctive category of payers need not report medical claims data to a state APCD, the database will not accurately reflect the availability and cost of local health-care services, and state authorities cannot rely on it to help them develop health-care policies with a robust evidentiary basis.⁶⁷

We encourage the agencies to recognize the importance of these efforts to compile and disseminate healthcare quality and price data and that bringing greater transparency to healthcare markets is an important step towards making them more competitive. For example, it may be possible to employ federal regulatory powers to overcome the obstacle to state-mandated transparency created by the *Gobeille* decision. As suggested by Justice Breyer in his concurrence, the U.S. Department of Labor, which regulates ERISA plans, could “develop reporting requirements that satisfy states’ needs” for APCDs.⁶⁸ We therefore urge the Agencies to monitor and support public and private initiatives to establish APCDs and similar databases that support informed consumer choice.

D. Encourage Pro-Competitive Policies at CMS

Medicare and Medicaid payment policies can have an important effect on competition. First it should be remembered that both programs depend on competitive provider and payer markets. Approximately 30% of Medicare beneficiaries are enrolled in Medicare Advantage plans, and prescription drugs are provided by private plans. Further, most states now contract with managed care organizations to provide services to their Medicaid beneficiaries.

The competitiveness of provider markets drives cost and quality for all payers, and most commercial payers pattern their payment methodologies after Medicare’s reimbursement methodology. Thus, the payment policies and rules governing participation in federal programs have an important effect on the cost and structure of markets in the private sector.

⁶⁶ See Nicolas Bagley, *The Supreme Court’s Wrongheaded Decision in Gobeille*, INCIDENTAL ECONOMIST (Mar. 3, 2016 11:50 AM), <http://theincidentaleconomist.com/wordpress/the-supreme-courts-wrongheaded-decision-in-gobeille/>.

⁶⁷ Brief for the States of New York, Maryland, Massachusetts, New Hampshire, Oregon, and Utah as Amici Curiae in Support of Petitioner, *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) (No. 14-181), 2014 WL 4652216.

⁶⁸ *Gobeille*, 136 S. Ct. at 949-50.

For this reason, we suggest that the Agencies engage in competition advocacy concerning CMS regulations just as it has done with the States.

In some instances, CMS policies may create incentives that work to lessen competition. To give one example, Medicare’s provider-based billing rules permit a hospital to bill a facility fee, in addition to a professional charge, for procedures performed by a physician in a hospital.⁶⁹ If the same procedure is done in a physician’s office or clinic, Medicare does not pay a facility fee. The result is Medicare often pays more for certain procedures when performed in a hospital than when performed in a physician’s office or clinic.⁷⁰ This provides strong incentives, completely untethered (and likely counter) to improving efficiency, for providers to shift the delivery of services to hospital settings. It also encourages providers to engage in regulatory strategies that do nothing for the patient and impose costs on the taxpayer (for example, under certain conditions, a hospital can license a physician’s clinic to be part of the hospital and charge an additional facility fee).

Because of the profound impact on competition of federal healthcare program regulation, we suggest therefore that the Administration inaugurate an interagency health competition task force to advise CMS on policies that affect the competitiveness of provider and payer markets. The Agencies’ should use this task force and other opportunities to advocate and support policies affecting payment, conditions of participation, and quality measures for providers that promote entry and cost-effective delivery of care.

IV. Policy Recommendations

America has chosen, wisely we think, to rely on competition to spur innovation, assure quality of care, and control costs in the healthcare sector. Where markets have been allowed to function under competitive conditions—free of anticompetitive regulations, cartels, and monopolies—competition has done its job. Much of the revolutionary change occurring today is designed to improve the function of healthcare markets and deal with problems of market failure and excessive regulation. In many areas however, problems persist. Many markets remain controlled by monopolies, constrained by outdated regulation, and foreclosed to new entrants and ideas from anticompetitive strategies from incumbents. We therefore believe the role of the federal antitrust agencies in making healthcare policy is a vital one, and they should be given the fullest support by Congress, the Executive branch and the States. In light of these observations, we offer a number of takeaways from the analysis that would help frame an active competition policy agenda that complements vigorous antitrust enforcement in healthcare. These include:

- **Traditional antitrust measures can prevent the agglomeration of additional harmful market power. However, less traditional and more creative, farsighted,**

⁶⁹ See Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 82 Fed. Reg. 52976 (Nov. 15, 2017) (codified as amended in scattered sections of 42 C.F.R.); see also O’Malley et al., *Rising hospital employment of physicians: Better Quality, Higher Costs?*, Issue Brief No. 136, CTR. FOR STUDYING HEALTH SYS. CHANGE (Aug. 2011).

⁷⁰ See Amanda Cassidy, *Health Policy Brief: Site-Neutral Payments*, HEALTH AFF. (July 24, 2014), <https://www.healthaffairs.org/doi/10.1377/hpb20140724.283836/full/>.

and proactive policies are necessary to police the harmful market power many healthcare entities have already amassed.

- COPA proceedings are unlikely to ascertain when consolidations will generate benefits that outweigh costs to competition. Given the weighty evidence that provider consolidations impose significant economic harm, COPA's frequently amount to evasions of needed FTC scrutiny.
- To mitigate the anticompetitive consequences of bundling monopolized and unmonopolized hospital services, antitrust enforcers ought to require hospitals and other provider entities to unbundle, at a purchaser's request, certain services so that the purchaser can negotiate prices. This offers a promising, proactive remedial approach to hospital mergers and would restore some lost competition from excessive consolidation.
- Contractual terms between providers and insurers such as MFNs and anti-steering provisions entrenches dominant providers and insurers, limiting competition and benefits to consumers. Antitrust rules can prohibit the use of such anticompetitive contractual terms and insurance regulators can bar such provisions wherever they threaten to preclude effective price competition.
- States should examine reducing barriers that prevent entry by upstart providers, from overly restrictive rules regarding facility licensure and CON. New outpatient surgery centers, retail clinics and urgent care facilities, and physicians are well positioned to offer alternatives to the traditional inpatient acute care facility.
- Insurance exchanges set up under the ACA offer a platform for effective price and quality comparisons across insurance products and are an important tool for combatting concentration in health insurance markets. While regulatory supervision is necessary in the health insurance markets, excessive regulation could undermine the viability of state insurance markets. The FTC and DOJ should monitor the development of these exchanges, help the states fine tune regulation, and encourage the promotion of pro-competitive regulatory strategies.
- The FTC and DOJ should invest in monitoring and advising state regulators regarding potential harms to competition arising from state regulations and policies. This includes advocating for liberalizing state licensure and scope-of-practice limitations. Where repeal is not feasible, states should consider clarifying standards for, and explicitly require consideration of the competitive impact of, CON determinations.
- State licensing boards dominated by market participants are prone to produce anticompetitive regulations. The FTC should take a proactive role in helping states craft regimes in which medical boards do not have inappropriate leeway without active state supervision. And because many states and Congress are considering how best to revise existing regulatory regimes, the FTC should

monitor and guide how policymakers implement mechanisms to actively supervise their professional boards.

- The FTC and DOJ should monitor and support public and private initiatives to establish APCDs and similar databases that compile and disseminate healthcare quality and price data. Greater transparency in healthcare markets can enhance competition and expand informed consumer choice.
- Federal healthcare program regulation has a profound impact on competition. As such, we suggest that the Administration inaugurate an interagency health competition task force to advise CMS on policies that affect the competitiveness of provider and payer markets. The FTC and DOJ should use this task force and other opportunities to advocate and support policies affecting payment, conditions of participation, and quality measures for providers that promote entry and cost-effective delivery of care.