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Antitrust and Healthcare Inequity

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Abstract

Eleanor Fox's recent scholarship addressing the development of antitrust policy in South Africa–and its efforts to recalibrate markets to address years of racial bias and suppression of Black, colored and Indian businesses–has inspired a dialog around the role of antitrust in addressing racism. This paper takes the debate to the US healthcare system and discusses how inequities in access to quality healthcare in the US can be unwittingly reinforced by antitrust policy. In the healthcare context, current antitrust enforcement emphasizes the impact of provider mergers on prices paid by private insurers. But does this narrow focus on the direct impact on a segment of customers ignore the complex economics of the US healthcare system and miss important implications for vulnerable communities? Should the "consumer welfare" standard contemplate a broader range of factors, including the need for significant resources to address healthcare inequities?

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"Does antitrust perpetuate structural racism?" After an intense year of racial turmoil amidst a global pandemic, this was the question addressed by Professor Fox and others at an antitrust bar event in January 2021.[1] The panel debated how the application of antitrust laws had reinforced or contributed to racial inequities, and how antitrust laws could potentially be reoriented to address these concerns. Professor Fox argued that the assumptions inherent in US antitrust law–that markets work well, and that competition is vibrant and keeps even dominant firms responsive to consumers–do not reflect reality and have created a hostile environment for small firms and new entrants, which are comprised in large measure by poorer people and people of color.[2]

The question of "antitrust racism" is one facet of the ongoing debate over the proper focus of the antitrust laws in the United States. The question has often been framed as whether we should continue to hew to a principled but narrow Chicago-school economic model, interpreting "consumer welfare" as limited to direct effects on customers and markets, or whether the antitrust laws should be interpreted more broadly to encompass the wider impact on the economy and society, including addressing social and racial inequities.[3] These questions are being discussed in the halls of academia, the chambers of Congress, and in numerous small and large conversations in the antitrust world.

This paper considers the impact of this debate on an area in which significant social and racial inequities persist today: the US healthcare system. Explanations abound for how the current lack of access to quality healthcare for socially and economically disadvantaged communities has arisen, and there are as many suggestions for ways to address it. But has antitrust enforcement exacerbated–or ameliorated–social and racial disparities in our healthcare system? Going forward, is there a role for antitrust in addressing these inequities?

I. Public Interest Considerations in Antitrust Enforcement

The security of current antitrust enforcement policy is in an analytical framework based on established economic principles. The underpinning of modern antitrust is a confidence in the ability of well-functioning markets to deliver benefits to all

1 *Does Antitrust Perpetuate Structural Racism?*, NYSBA Antitrust Section Annual Meeting (Jan. 22, 2021): Professor Eleanor M. Fox, NYU School of Law; Commissioner Rebecca Slaughter, FTC; Sandeep Vaheesan, Open Markets Institute; Leslie Overton, Axinn, Veltrop & Harkrider LLP; Deona Kalala, Alston & Bird; and Jay Himes, Labaton Sucharow (moderator).

2 *Id.*

3 There is a wide range of views on this topic, including some who argue that the consumer welfare standard already is capable of taking social issues into account, and others who advocate for a new formulation. *See* Am. Bar Ass'n Antitrust Law Section, Report on the Task Force on the Future of Competition Law Standards (2020), www.americanbar.org/content/dam/aba/administrative/antitrust_law/aba-antitrust-standards-task-force-report.pdf [hereinafter Competition Standards Report]; Sandeep Vaheesan, *How Antitrust Perpetuates Structural Racism*, The Appeal (Sept. 16, 2020), https://theappeal.org/how-antitrust-perpetuates-structural-racism/.

consumers. Such benefits are typically defined in terms of prices, quality, innovation, and occasionally access to product range or diversity. While some may criticize this formulation of the consumer welfare approach as too narrow (in particular its emphasis on price effects), it is relatively well understood and provides a measure of predictability in how the antitrust agencies will approach any transaction.

There has been significant criticism of the notion that antitrust is an appropriate mechanism for addressing social and racial inequities.[4] Critics argue that there are other, better avenues through which the government can pursue such policy goals, and that it is not the role of competition policy to pursue social aims over economic goals.[5] Among OECD countries, the practice of most antitrust regulators is to stay close to the core economic goals in competition law–allocative efficiency and consumer welfare.[6] Regulators generally avoid use of so-called "public interest" factors that risk the transparency and predictability of their merger control systems, and that would jeopardize consistency of cross-border merger reviews.[7]

The economic rationality of the current approach is attractive and comfortable. It appears to follow an objective application of principles that do not incorporate value judgments or consciously nest social and racial biases. But does adherence to such "neutral" economic principles that consider consumer welfare only in these terms unwittingly harm society, in particular vulnerable communities? Should our focus on direct economic impacts and harms to customers require that we ignore the broader effects of enforcement decisions, which may also have more indirect impacts on the economy? Is the consumer welfare standard being properly enforced if it does not account for inequality? In insisting on apparent neutrality, are we actually supporting an inequitable status quo?

Professor Fox has challenged the notion that bringing "non-market discourse" into antitrust analysis challenges the limits and predictability of antitrust rules. She notes:

> We do have to confront the question of the relevance of non-market factors. We can confront it more cleanly if we don't insist: "stick with consumer welfare, or lose the legitimacy of antitrust." … To the

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4 Elyse Dorsey et al., *Hipster Antitrust Meets Public Choice Economics: The Consumer Welfare Standard, Rule of Law, and Rent-Seeking*, Competition Pol'y Int'l Antitrust Chronicle (Apr. 2018). Joshua D. Wright & Douglas H. Ginsburg, *The Goals of Antitrust: Welfare Trumps Choice*, 81 Fordham L. Rev. 2405, 2405–09 (2013); Christine S. Wilson, Commissioner, Fed. Trade Comm'n, Address at the British Institute of International and Comparative Law, Remembering Regulatory Misadventures: Taking a Page from Edmund Burke to Inform Our Approach to Big Tech 13–18 (June 28, 2019), www.ftc.gov/system/files/documents/public_statements/1531816/wilson_remarks_biicl_6-28-19.pdf; A. Douglas Melamed, *Antitrust Law and Its Critics,* 83(1) Antitrust L.J. 14–17 (2020).

5 *See* Dorsey et al., *supra* note 4; Competition Standards Report at 18–19.

6 OECD, Working Party No. 3 on Co-operation and Enforcement, Executive Summary of the Roundtable on Public Interest Considerations in Merger Control (DAF/COMP/WP3/M(2016)1, June 14, 2016), https://one.oecd.org/document/DAF/COMP/WP3/M(2016)1/ANN5/FINAL/en/pdf.

7 *Id.*

> extent that the competition laws of various nations incorporate non-market goals, the systems will have to work hard to make the laws administrable and predictable.[8]

This debate is taking practical form in South Africa, which has included in its antitrust laws express provisions aimed at promoting the country's post-apartheid social and economic goals.[9] These laws stand in stark contrast to US antitrust laws. In fact, aspects of current US competition policy could arguably be defined as the inverse of South African competition law. Where South African law would facilitate a small business's prima facie case of the existence of discrimination or excessive pricing, and shift the onus of proof to an incumbent defendant (which likely gained its status in an environment where competition from Black, colored or Indian companies was suppressed), US law would require allegations and proof of broader harms to markets beyond the ability of that individual enterprise to participate. Even the somewhat outdated US laws prohibiting price discrimination–enacted expressly to protect small businesses–generally require proof of harm to competition across an entire market, not to an individual affected company.

The prevailing approach to antitrust enforcement in the US may be changing. The current debate around the future of the antitrust laws in the US consistently identifies concerns broader than simply price effects. The Committee on the Judiciary investigation into the state of competition online sought to identify how actors in the digital economy "affect[] our economy and our democracy."[10] In addition to examining price, quality and innovation effects, the investigation also looked at impacts on non-economic goals, such as a free and diverse press and privacy.[11] There are several recent legislative proposals to amend the US antitrust law that seek to introduce new presumptions and burden-shifting to address the perceived imbalance between large enterprises and society at large.[12] While the current focus is mainly on antitrust and digital platforms, similar considerations could apply when considering antitrust enforcement in healthcare markets.

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8 CPI, *South Africa, CPI Talks … Eleanor Fox*, 2 Competition Pol'y Int'l Antitrust Chronicle (Nov. 7, 2019), www.competitionpolicyinternational.com/cpi-talks-eleanor-fox/.

9 Eleanor Fox, *South Africa, Competition Law and Equality: Restoring Equity by Antitrust in a Land Where Markets Were Brutally Skewed*, 3 Competition Pol'y Int'l Antitrust Chronicle (Dec. 9, 2019).

10 Majority Staff of Subcomm. on Antitrust, Comm. and Admin. Law, 116th Cong., Investigation of Competition in Digital Markets 6 (2020), https://judiciary.house.gov/uploadedfiles/competition_in_digital_markets.pdf?utm_campaign=4493-519.

11 *Id.* at 57–73. Similarly, other commentators such as Joseph Stiglitz advocate for expanding antitrust law to advance "the public interest" – specifically to protect consumer interests in privacy and legal recourse for dispute resolution, prevent excessive risk-taking by firms, improve workers' bargaining power, and bolster the "marketplace of ideas" in media. Joseph E. Stiglitz, *Towards a Broader View of Competition Policy*, 12–13, 18–19 (Roosevelt Inst. Working Paper, June 2017) (on file with the Roosevelt Institute), https://rooseveltinstitute.org/wp-content/uploads/2020/07/RI-Broader-View-of-Competition-Policy-201703.pdf; Joseph E. Stiglitz, Professor, Columbia Business School, The Graduate School of Arts and Sciences, Columbia University, Remarks at Fed. Trade Comm'n Hearings on Competition and Consumer Protection in the 21st Century 23–25 (Sept. 21, 2018), www8.gsb.columbia.edu/faculty/jstiglitz/sites/jstiglitz/files/Stiglitz%20FTC%20Hearing%20PPT%20FINAL.pdf.

12 *See, e.g.*, Competition and Antitrust Law Enforcement Reform Act of 2021, S. 225, 117th Cong. (2021), www.congress.gov/117/bills/s225/BILLS-117s225is.pdf.

II. Healthcare Economics and Inequity in Healthcare Access

There is no question that there are significant disparities and inequities in access to quality healthcare by economically and socially disadvantaged communities in the United States.[13] The consequences of these disparities are manifest–higher infant mortality for Black babies than for White babies; lower life expectancy for Black men and women than for their White counterparts; higher diabetes rates among Native Americans and Latinos; higher rates of death from heart disease, stroke, and prostate and breast cancers in Black populations.[14] As well as having adverse impacts on the economy, the situation raises serious moral and ethical dilemmas–how can a nation with such world-class healthcare facilities, technologies, and pharmacotherapeutics tolerate such poor access to those assets by underprivileged segments of its own population?

These disparities have their roots in the development of the healthcare economy over the last century against a backdrop of racial and social bias. They are reflected in the complex structures and economics of the current US healthcare system, involving multiple private and public actors, a wide range of providers, and myriad communities, all with varying interests and priorities. While the ultimate goal is for all Americans to have access to the best possible care and live healthy lives, the routes to that goal are at best circuitous.

The difficulties of US healthcare are in part due to the complexity of payment flows in the healthcare delivery system. A significant portion of healthcare in the US is accessed through private insurance.[15] Because healthcare is a semi-free-market economy, bargaining leverage matters. Depending on market structure, the size of the payor or provider dictates how much private payors will pay for healthcare services to be accessed by their subscribers. Individuals of course have no leverage: Ironically, those who are uninsured and therefore not receiving care at payor-negotiated rates are typically the least able to pay higher rates, resulting in "healthcare bankruptcies" and a significant volume of care for which providers ultimately remain uncompensated.

There also is a significant aspect of the healthcare system not subject to such market forces–Medicare and Medicaid programs–where rates are dictated by, rather than

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13 *See* Margaret M. Heckler, US Dep't of Health and Human Serv., Report of the Secretary's Task Force on Black and Minority Health, Vol. 1: Exec. Summary (1985); Nat'l Research Council, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Brian D. Smedley et al. eds., 2003.).

14 Wayne J. Riley, *Health Disparities: Gaps in Access, Quality and Affordability of Medical Care* 123 Transactions of the Am. Clinical and Climatological Ass'n 167, 167–68 (2012).

15 CDC data on personal healthcare expenditures by source of funds provides the breakdown: 35% private health insurance; 23% Medicare; 17% Medicaid; 12% out of pocket; and 13% other (including Children's Health Insurance Program, Veterans Affairs programs, and a variety of other third party payors and programs, such as worksite health care, vocational rehabilitation, and school health programs). *See* Nat'l Ctr. for Health Statistics, Ctr. for Disease Control and Prevention, Personal Health Care Expenditures, by Source of Funds and Type of Expenditure: United States 2008–2018 (2019), www.cdc.gov/nchs/data/hus/2019/fig18-508.pdf.

negotiated with, a government payor.[16] These rates are often below the cost of providing care: on an average basis, even the most efficient hospitals operate at a negative margin on Medicare rates,[17] and Medicaid rates are even lower. This complex and variable web of different payments for the same services leaves providers balancing the books with private payor rates: private insurance often buoys up the ship when public-pay and uncompensated care would threaten to sink it.[18]

The efforts to reform healthcare have sought to create a more equitable healthcare system by addressing three closely related goals–access, quality and cost. The inability to access quality healthcare (often due to its cost) creates and exacerbates inequities. There is a plethora of healthcare literature documenting racial and ethnic disparities in healthcare and how these disparities may be addressed.[19]

Healthcare reform advocates identify a wide range of strategies for ensuring access to quality healthcare for vulnerable communities.[20] Each of these strategies, however, requires a significant commitment and investment of resources to be realized. For example, a key element for supporting the health of disadvantaged communities is addressing the "social determinants" of health–factors such as economic stability (food security, housing, and employment), environment (such as clean air and water), and social and community support. In order to incorporate and address these concerns into their provision of healthcare services, providers need to devote energy and resources to identify systematically what specific issues face their patient population, and to develop partnerships with other providers and community stakeholders. Similarly, adopting new virtual care strategies, such as telehealth, to expand access to underserved communities also requires a significant investment in technology.[21] These investments

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16 *Id.*

17 Susan Morse, *Efficient Hospitals Operate on -2% Margins in Medicare Payments, MedPAC Reports*, Healthcare Finance (Mar. 15, 2019), www.healthcarefinancenews.com/news/efficient-hospitals-operate-2-margins-medicare-payments-medpac-reports. Another commonly cited metric of hospital profitability is the payment-to-cost ratio, which represents average payment relative to average cost by payer, accounting for both patient-specific clinical costs and fixed costs such as equipment, buildings, or administrators' salaries. "According to the American Hospital Association (AHA), private insurance payments average 144.8% of cost, while payments from Medicaid and Medicare are 88.1% and 86.8% of cost, respectively." Emily Gee, *The High Price of Hospital Care*, Ctr. for Am. Progress (June 26, 2019), www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/#fn-471464-30.

18 Rick Mayes & Jason S. Lee, *Medicare Payment Policy and the Controversy Over Hospital Cost Shifting*, 3 Applied Health Econ. and Health Pol'y 153 (2004); Roger Feldman, et al., *Medicare's Role in Determining Prices Throughout the Health Care System* (Mercatus Ctr. Working Paper, 2015), www.mercatus.org/system/files/Feldman-Medicare-Role-Prices-oct.pdf.

19 *See* Kevin Fiscella, *Health Care Reform and Equity: Promise, Pitfalls, and Prescriptions* 9 Ann. of Fam. Med. 78, www.ncbi.nlm.nih.gov/pmc/articles/PMC3022050/ and articles cited therein.

20 *See, e.g.*, Am. Hosp. Ass'n, Report of American Hospital Association Task Force on Ensuring Access in Vulnerable Communities (2016), www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf; Jay Bhatt & Priya Bathija, *Ensuring Access to Quality Health Care in Vulnerable Communities*, 93 Acad. Med. 1271 (2018) and articles cited therein; Deborah Bachrach et al., The Commonwealth Fund, High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid (2012), www.commonwealthfund.org/publications/fund-reports/2012/nov/high-performance-health-care-vulnerable-populations-policy.

21 One recent study investigating the use of telehealth during the COVID-19 pandemic found that Black respondents are most likely to report using telehealth because of the COVID-19 pandemic (particularly when they perceive the pandemic as a minor health threat), concluding that opportunities to leverage a broadly defined set of telehealth tools help to reduce healthcare disparities post-pandemic. Celeste Campos-Castillo

are unlikely to generate any return on investment as understood in direct economic terms, but rather address underlying inequities and serve to support the overall health of the community, which ultimately will have benefits for the economy writ large.

The healthcare policy literature rarely cites competition as an element through which healthcare inequities can be managed for the better. In fact, many of the efforts being made to address disparities run counter to current competition policy. Take the rules imposed on health insurers by the Mental Health Parity and Addiction Equity Act–they prohibit imposing deductibles, co-pays, and OOP limits on mental health and substance abuse coverage that are higher than those imposed for medical-surgical coverage, and make similar parity mandates for hospital stays. Left to itself, the market is unlikely to have reached that result. But, from a policy perspective, such constraints on the market are necessary to achieve equitable results for a vulnerable segment of the population.

The financial pressures on the healthcare system, in particular on hospitals and physician practices, are likely to become more intense following the COVID-19 pandemic, particularly if the volume of uninsured or Medicaid patients increases due to higher unemployment. The federal government has allocated funds through a variety of programs to support healthcare providers in the wake of the crisis.[22] But Kaiser Foundation analysis questions whether the infusion of funds will be sufficient to stabilize providers who are least equipped to weather this revenue decline.[23] These factors will place even more limitations on providers' ability to fund programs specifically designed to address social disparities in healthcare delivery.

III. Antitrust Enforcement in Healthcare Markets

The US antitrust agencies–the Federal Trade Commission (FTC) and US Department of Justice Antitrust Division (DOJ) – have given significant thought to the role of antitrust enforcement in the healthcare industry over at least the last 25 years, holding several sets of hearings and publishing statements of enforcement policy,[24] influential reports,[25] and numerous advisory opinions.

& Denise Anthony, *Racial and Ethnic Differences in Self-Reported Telehealth Use During the COVID-19 Pandemic: A Secondary Analysis of a US Survey of Internet Users from Late March*, 28 J. Am. Med. Informatics Ass'n 119, 122–24 (2020), https://academic.oup.com/jamia/article/28/1/119/5902454.

22 *E.g.*, the Coronavirus Aid, Relief, and Economic Security Act, 15 U.S.C. §§ 9001–9080 (2020); the Paycheck Protection Program and Health Care Enhancement Act, 15 U.S.C. §§ 636, 9006, 9009 (2020).

23 Karyn Schwartz & Anthony Damico, *Distribution of CARES Act Funding Among Hospitals*, Kaiser Family Foundation (May 13, 2020), www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/.

24 *See, e.g.*, US Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996), www.justice.gov/atr/page/file/1197731/download; US Dep't of Justice & Fed. Trade Comm'n, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2011), www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf.

25 *See, e.g.*, US Dep't of Justice & Fed. Trade Comm'n, Improving Health Care: A Dose of Competition (2014), www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf [hereinafter Improving Health Care].

The work of the antitrust agencies has been consistent with a great deal of ongoing economic and policy work in the healthcare area. Many of the recommendations for improving competition in healthcare markets identified in the 2004 *Improving Health Care* report[26]–such as tying payments to results; lowering barriers to competitor access through telehealth and relaxation of licensing requirements; improving efficiency through expanded use of technology (particularly electronic medical records systems); and encouraging pricing transparency–echo those of other policymakers and have made their way into our current system through a variety of healthcare reform efforts.

While recognizing the complex and market-distorting features of healthcare delivery markets, the bottom-line conclusion of the agencies' efforts is that antitrust should apply to healthcare markets just as it does to other industries. In the 2004 report, the drafters concluded: "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty–even when complex products and services such as health care are involved."[27]

But viewing transactions and conduct in healthcare markets through the current antitrust lens typically results in a process that considers only private insurer prices. This can have inequitable results: When dealing with facilities serving disadvantaged communities, ignoring or deemphasizing considerations of access and impacts on the local community arguably perpetuates the status quo. A focus on price, rather than quality, may overlook those factors most likely to impact patients who are on Medicare or Medicaid, or who are uninsured. Without the increased access to capital and other advantages that come with participating in a larger organization, the hospital is left to continue on, in many cases efficiently using their current resources, but without the capacity to make transformative improvements in operations or to invest in the local community.

Making such arguments in response to competitive concerns around price effects face significant difficulties under the agencies' Horizontal Merger Guidelines. The Guidelines set a very high bar for giving weight to transaction efficiencies and the economic condition of merging firms.[28] To be cognizable, efficiencies have to be quantifiable and verifiable. Quality enhancement rarely meets this requirement, and enhanced access or impacts on disadvantaged communities never will. Similarly, the agencies will permit an acquisition of a "failing firm," but the standards by which a firm is to be considered "failing" are again very high–the financial condition of the hospital must be so dire that it is in danger of closing and there can be no alternative purchaser that would have maintained

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26 *See id.* at 21–24.

27 *Id.* at 28–29.

28 *See* US Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines §§ 10–11 (2010), www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf.

the facility as a competitor.[29] The criteria for invoking these justifications for a transaction are rarely achieved.

Since at least 2000, these elements of US merger antitrust enforcement have played out in several successful court challenges by the FTC against mergers of competing hospitals, and the abandonment of many others in the face of FTC pre-complaint opposition.[30] Those cases have focused on the impact on the negotiating dynamic between hospital providers and private insurers, and rarely the (usually unquantifiable) benefits that such transactions may bring to their surrounding communities, in particular vulnerable and otherwise disadvantaged populations. Most merger antitrust enforcement is based around a concern that allowing hospital systems to get bigger can result in higher rates to private payors.[31] But assessing a merger by its impact on private payor pricing does not consider the overall economic impact on a provider with significant public-pay and uncompensated care. It also does not consider the potential collateral damage that rejecting certain transactions may have on their communities, those considerations being well outside the scope of current interpretations of the antitrust laws. These concerns may be exacerbated by the financial pressures faced by hospitals coming out of the COVID-19 pandemic.

In response to the narrow focus of federal antitrust enforcement, several states have adopted the approach of shielding hospital mergers and other conduct that may violate the antitrust laws as interpreted by the federal antitrust agencies. Such "Certificate of Public Advantage" (COPA) laws displace federal antitrust enforcement in favor of a state assessment (typically conducted by a state health department) of the public benefits of permitting a transaction that may outweigh any potential anticompetitive effects.[32] The FTC has vehemently opposed COPA laws–and the transactions approved under them–and has been active in regulatory proceedings leading to the grant of a COPA. However, in many instances, states have elected to grant a COPA and permit a merger to proceed, subject to stringent conditions that often include long-term price regulation to protect against

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29 *See, e.g.*, Richard Feinstein, Bureau of Competition Director, Fed. Trade Comm'n, Statement on the FTC's Closure of its Investigation of Consummated Hospital Merger in Temple, Texas (Dec. 23, 2009), www.ftc.gov/sites/default/files/documents/public_statements/ftcs-closure-its-investigation-consummated-hospital-merger-temple-texas/091223scottwhitestmt.pdf.

30 *See* Markus H. Meier et al., Health Care Division, Fed. Trade Comm'n, Overview of FTC Actions in Health Care Services and Products 51–72 (2019), www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf.

31 Whether this will be true in any particular case depends on the structure of the specific market, however, there is a significant body of economics literature that supports this view. *See* Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* (Nat'l Bureau of Econ. Research, Working Paper No. 21815, 2015), https://doi.org/10.3386/w21815; Medicare Payment Advisory Comm'n, March 2020 Report to the Congress: Medicare Payment Policy xxv–xxvi (Mar. 13, 2020), www.medpac.gov/docs/default-source/reports/mar20_entirereport_rev_sec.pdf?sfvrsn=0.

32 COPA laws can also insulate certain conduct, such as collaborations between competing entities to organize the treatment of Medicaid beneficiaries between them. *See, e.g.*, N.Y. Pub. Health Law Art. 29–F § 2999-A, www.nysenate.gov/legislation/laws/PBH/2999-AA.

anticipated price increases to payors as a result of the increased bargaining leverage.[33]

In other instances, states have acted independently without COPA laws in obtaining commitments and conditions for permitting a transaction to proceed even while the FTC was investigating or in the midst of a formal challenge. In these instances, in the interests of comity, the FTC has stepped back from its enforcement action and permitted the transaction to close under the aegis of the state regulator.[34] But this is not the agency's preferred approach:

> The resolution of hospital merger challenges through community commitments should be generally disfavored. The Agencies do not accept community commitments as a resolution to likely anticompetitive effects from a hospital (or any other) merger. The Agencies believe community commitments are an ineffective, short-term regulatory approach to what is ultimately a problem of competition. Nevertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face.[35]

In the cases in which COPAs have been granted or conditions otherwise agreed, the states elected to take on a regulatory role to realize community benefits rather than a strict economic approach that would leave competition and the free market to determine commercial insurance rates. While expressing opposition to the displacement of the benefits of competition by local interests, both as a matter of principle and in relation to specific transactions, the FTC's forbearance in these matters suggests an acknowledgment of the complexity of healthcare policy concerns and the inability of current antitrust enforcement paradigms to address these concerns. As the 2004 report notes:

> Competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health

33 *See, e.g.*, 2017–18 COPAs granted to Wellmont and Mountain States healthcare organizations to form Ballad Health in Tennessee and Virginia. *Certificate of Public Advantage (Tennessee) & Cooperative Agreement (Virginia)*, Ballad Health, www.balladhealth.org/copa; 2020 COPAs granted to Shannon Health for the acquisition of San Angelo Community Medical Center and to Hendrick Health System for its acquisition of Abilene Regional Medical Center. *Certificate of Public Advantage*, Texas Health and Human Serv., https://hhs.texas.gov/doing-business-hhs/provider-portals/health-care-facilities-regulation/certificate-public-advantage.

34 *See, e.g.*, Fed. Trade Comm'n, Statement Concerning the Proposed Affiliation of CareGroup, Inc.; Lahey Health System, Inc.; Seacoast Regional Health System, Inc.; BIDCO Hospital LLC; and BIDCO Physician LLC (Nov. 29, 2018), www.ftc.gov/system/files/documents/closing_letters/nid/1710118_bidmc_commission_closing_statement.pdf; Harold Brubaker, *Pa. Attorney General drops opposition to Jefferson-Einstein deal*, Phila. Inquirer, Jan. 12, 2021, www.inquirer.com/business/health/pennsylvania-attorney-general-drops-opposition-jefferson-einstein-merger-20210112.html; *Einstein Healthcare Network and Jefferson Health Merger Clears Final Hurdle*, Jefferson Health (Mar. 1, 2021), https://hospitals.jefferson.edu/news/2021/03/einstein-jefferson-health-merger.html.

35 Improving Health Care, *supra* note 25 at 27.

> care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them.[36]

In many ways, state efforts in healthcare transactions that displace antitrust enforcement are an experiment. Will they actually deliver on the promises of advancement of local healthcare objectives and actively improve healthcare access for vulnerable communities? Has the elimination of inter-hospital competition actually resulted in higher commercial prices and lower quality? The agencies and policymakers are standing by ready to assess the results. The FTC has held workshops and has been studying the impact of mergers consummated under COPAs since 2019.[37] It also is studying the impact of physician group and hospital mergers.[38] This work will inform both future enforcement as well as help healthcare policymakers identify ways to ensure the potential benefits of consolidation reach disadvantaged communities, or take a different approach.

The complex US healthcare system itself is not standing still. Proposals abound for expanding access for vulnerable communities through a variety of means, including expanding existing public programs, strengthening policies around private insurance, implementing quality and other incentive programs, encouraging collaborations between different providers and community organizations, and many others.[39] Several of these will clash with the traditional application of the antitrust laws. As existing healthcare structures develop and change, antitrust will need to adjust and continue to be part of the debate.

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36 *Id.* at 4.

37 *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Market*s, Fed. Trade Comm'n, www.ftc.gov/news-events/events-calendar/health-check-copas-assessing-impact-certificates-public-advantage; Press Release, Fed. Trade Comm'n, FTC to Study the Impact of COPAs (Oct. 21, 2019), www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas.

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Antitrust Ambassador to the World

Liber Amicorum

Pioneer, avant-garde, transformationalist - Eleanor M. Fox is regularly described in these terms by the manifold antitrust practitioners who have been influenced by her industry-shaping scholarly work. Over the course of an extraordinary career, she has helped establish a coherent set of competition law and policy principles designed to promote markets that work in favor of inclusivity, and to ensure economic development that reduces unequal access to markets. Her mold-breaking contributions to the tailored development of competition law in developing economies are acknowledged today across international forums that she helped create. This book honours Professor Fox's indelible mark on antitrust law and policy with contributions from her friends and colleagues around the world. The articles explore subjects such as the role of competition policy, its intersection with social policies, external pressures, and challenges for developing economies amongst others.

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