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BUYER POWER AND HEALTHCARE PRICES

John B. Kirkwood*

Abstract: One major reason why healthcare spending is much higher in America than in other countries is that our prices are exceptionally high. This Article addresses whether we ought to rely more heavily on buyer power to reduce those prices, as other nations do. It focuses on two sectors where greater buyer power could easily be exercised: prescription drugs covered by Medicare and hospital and physician services covered by private insurance.

The Article concludes that the biggest buyer of all, the federal government, should be allowed to negotiate Medicare prescription drug prices. This would likely reduce the prices of many branded drugs substantially without causing a large reduction in innovation. Multiple studies indicate that drug companies have been exceptionally profitable in recent years. As a result, they could lower prices on many drugs and still earn a competitive return on most research and development. Moreover, the incentive to develop important new medicines would remain high because the government would have little leverage over the prices of these drugs. Finally, if problems with innovation develop, payments for new drugs can be increased.

In contrast, encouraging large insurance companies to merge does not appear to be a promising way of lowering healthcare costs. While some large mergers may be procompetitive—lowering both excessive provider prices and insurance premiums—most would present significant competitive risks. They may allow the merged firm to exert monopsony power over small providers, they may create market power and lead to higher premiums, or they may permit the merged firm to gain a discriminatory advantage over smaller insurance companies, threatening downstream competition. Because of these dangers, it would not be wise, as a general rule, to permit large health insurers to merge.

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* Professor of Law, Seattle University School of Law, and Senior Fellow, American Antitrust Institute. I want to thank Bill Comanor, Doug Ross, Tim Greaney, Sallie Sanford, David Frankford, David Hyman, Maggie Chon, Lily Kahng, Charlotte Garden, Kelsey Kirkwood, and participants in this symposium and a faculty workshop at Seattle University for their thoughtful comments and suggestions. I also want to acknowledge, once again, the excellent research assistance I have received from Kelly Kunsch.

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INTRODUCTION

Healthcare prices in the United States are exceptionally high. Many studies have found that the United States spends nearly twice as much per capita on healthcare as other developed countries, while achieving inferior results on such important public health measures as life expectancy and infant mortality.¹ When analysts try to explain why we spend more than other advanced nations, they frequently point to the higher prices we pay: many healthcare goods and services are more expensive in America than they are abroad.² Medicare pays four times as

1. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 28 (2014) [hereinafter MEDPAC], http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0 [<https://perma.cc/P8QJ-PV45>].

The United States spends more on health care, both per capita and as a share of gross domestic product (GDP), than any of the 34 countries that are members of the Organisation for Economic Co-operation and Development (OECD). At the same time, the United States ranks 26th in life expectancy and 31st on infant survival rates of the 34 OECD countries.

Id.; see also Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (Mar. 4, 2013), <http://healthland.time.com/2013/02/20/bitter-pill-why-medical-bills-are-killing-us> [<https://perma.cc/3W7G-TQZP>] (“In the U.S., people spend almost 20% of the gross domestic product on health care, compared with about half that in most developed countries. Yet in every measurable way, the results our health care system produces are no better and often worse than the outcomes in those countries.”).

2. See, e.g., MEDPAC, *supra* note 1, at 28 (“[H]igher U.S. spending levels are attributable to the nation’s significantly higher prices for health care services and not to greater utilization of hospital and physician services.”); EZEKIEL J. EMANUEL, REINVENTING AMERICAN HEALTH CARE 220 (2014) (“Substantial research has shown that the prices paid for health care services in the United

much for CT scans as Germany does.³ The cost of a hip replacement in the United States is over five times the cost in Brussels and the U.S. price includes fewer services.⁴ Professor Emanuel notes:

[a]merican physicians and nurses [earn] much more than their counterparts in Europe, Australia, and other developed countries. Prices for brand-name drugs—although not generics—are much higher in the United States than they are in other countries. Prices for routine tests, such as MRIs and CT scans, are higher in the United States than they are in Japan and other countries. For instance, an MRI in Japan is \$160, while in the United States it averages \$1,700.⁵

Healthcare prices are not only high but have been rising rapidly for many years, faster than the overall rate of inflation. Between 2000 and 2010, the proportion of gross domestic product (GDP) accounted for by healthcare increased from 13.8% to 17.9%.⁶ “Much of this increase,” according to Professors Blair and Durrance, “can be attributed to rising

States are high.”); Uwe E. Reinhardt et al., *U.S. Health Care Spending in an International Context*, 23 HEALTH AFF. 10, 12 (2004) (“Americans pay much higher prices for the same health services than citizens in other countries pay.”). High prices are not, however, the only cause of America’s relatively poor public health results. See Eduardo Porter, *Income Inequality Is Costing the Nation on Social Issues*, N.Y. TIMES, Apr. 29, 2015, at B1, http://www.nytimes.com/2015/04/29/business/economy/income-inequality-is-costing-the-us-on-social-issues.html?_r=0 (“The United States has the highest teenage birthrate in the developed world—about seven times the rate in France, according to the O.E.C.D. More than one out of every four children lives with one parent, the largest percentage by far among industrialized nations. And more than a fifth live in poverty, sixth from the bottom among O.E.C.D. nations.”); see also *id.* at B8 (“American babies born to white, college-educated, married women survive as often as those born to advantaged women in Europe. It’s the babies born to nonwhite, nonmarried, nonprosperous women who die so young.”).

3. Brill, *supra* note 1.

4. Roger D. Blair & Christine Piette Durrance, *Patents, Monopoly Pricing, and Antitrust in Health Care Markets*, ANTITRUST SOURCE, Apr. 2014, at 1, 2 (citing Elisabeth Rosenthal, *For Medical Tourists, Simple Math*, N.Y. TIMES, Aug. 3, 2013, at A1).

5. EMANUEL, *supra* note 2, at 220–21; see also Brill, *supra* note 1 (“McKinsey & Co. researchers reported that overall prescription-drug prices in the U.S. are ‘50% higher for comparable products’ than in other developed countries.”); MARC-ANDRÉ GAGNON & SIDNEY WOLFE, MIRROR, MIRROR ON THE WALL: MEDICARE PART D PAYS NEEDLESSLY HIGH BRAND-NAME DRUG PRICES COMPARED WITH OTHER OECD COUNTRIES AND WITH U.S. GOVERNMENT PROGRAMS 7 (2015) (new data indicate that in 2014 the median OECD price on patented drugs was only forty-two percent of the U.S. price); Jeanne Whalen, *Why the U.S. Pays More than Other Countries for Drugs: Norway and Other State-Run Health Systems Drive Hard Bargains, and Are Willing to Say No to Costly Therapy*, WALL ST. J. (Dec. 1, 2015), <http://www.wsj.com/articles/why-the-u-s-pays-more-than-other-countries-for-drugs-1448939481> [<https://perma.cc/U823-REDQ>] (“A vial of the cancer drug Rituxan cost Norway’s taxpayer-funded health system \$1,527 in the third quarter of 2015, while the U.S. Medicare program paid \$3,678. An injection of the asthma drug Xolair cost Norway \$463, which was 46% less than Medicare paid for it.”).

6. Blair & Durrance, *supra* note 4, at 1.

prices.”⁷ From 2000 to 2013, the consumer price index increased by 35%, while the medical component increased by 63%.⁸ Although healthcare inflation has slowed recently, it is likely to pick up again as the economy improves.⁹ One notable cause is the escalating prices of new brand name prescription drugs. Kalydeco, a new specialty drug, now costs more than \$300,000 a year,¹⁰ and UnitedHealth Group has estimated that specialty drug spending could quadruple in less than a decade, from \$87 billion in 2012 to \$400 billion in 2020.¹¹ Similarly, the prices of anticancer drugs have soared, with new treatments now costing more than ten times what they cost two decades ago, but with the benefits—additional survival time—often stated in months rather than years.¹² Finally, as Turing’s notorious 5400% increase in the price of Daraprim quickly demonstrated, there is “growing concern about huge price increases on older drugs, some of them generic, that have long been mainstays of treatment.”¹³ Together, these developments have generated “public outrage against the growing trend of higher and higher drug prices imposed by big drug companies.”¹⁴

7. *Id.*

8. *Id.*

9. See Ezekiel Emanuel & Topher Spiro, *The Coming Health-Care Cost Shock*, WALL ST. J., July 8, 2015, at A11; Margot Sanger-Katz, *Health Spending Is Expected to Rise as Slowdown Ends*, N.Y. TIMES, July 29, 2015, at B2. *But see* David Brooks, *Great News! We’re Not Doomed*, N.Y. TIMES, Nov. 6, 2015, at A27 (“We seem to be making at least some incremental progress toward a structural reduction in health care inflation.”).

10. Joe Nocera, *The \$300,000 Drug*, N.Y. TIMES, July 19, 2014, at A19.

11. Joseph Walker, *A Costly Drug Is Denied, and Medicaid Takes Heat*, WALL ST. J., July 17, 2014, at A1; *see also* Karen Ignagni, *Paying for the Thousand-Dollar Pill*, WALL ST. J., Aug. 4, 2014, at A11 (“Specialty drugs, which only make up 1% of prescriptions, already account for 25% of total U.S. drug spending, moving toward 50%.”).

12. See Hagop Kantarjian et al., *High Cancer Prices in the United States: Reasons and Proposed Solutions*, 10 J. ONCOLOGY. PRAC. 208, 208 (2014).

The average cancer drug price for approximately 1 year of therapy or a total treatment duration was less than \$10,000 before 2000, and had increased to \$30,000 to \$50,000 by 2005. In 2012, 12 of the 13 new drugs approved for cancer indications were priced above \$100,000 per year of therapy.

Id.; David H. Howard et al., *Pricing in the Market for Anticancer Drugs*, 29 J. ECON. PERSP. 139, 140 (2015) (finding that “the average launch price of anticancer drugs, adjusted for inflation and health benefits, increased by 10 percent annually—or an average of \$8,500 per year—from 1995 to 2013”); *id.* at 141 (“Gains in survival time associated with recently approved anticancer drugs are typically measured in months, not years.”).

13. Andrew Pollack, *Once a Neglected Treatment, Now an Expensive Specialty Drug*, N.Y. TIMES, Sept. 21, 2015, at B1 (noting that Turing raised Daraprim’s price to “\$750 a table from \$13.50” and that “Cycloserine, a drug used to treat dangerous multidrug-resistant tuberculosis, was just increased in price to \$10,800 for 30 pills from \$500 after its acquisition by Rodelis Therapeutics”).

14. Andrew Pollack & Sabrina Tavernise, *A Drug Company’s Price Tactics Pinch Insurers and*

America's high and rising healthcare prices spring from many causes. Among them are the continuing introduction of more effective— but more expensive— treatments; widespread insurance coverage, which reduces the incentive to look for low-cost providers; the absence of transparent pricing information, which inhibits the search for those providers; and patent protection for pharmaceuticals, which blocks for years the emergence of low-cost competitors.¹⁵ These causes, moreover, contribute to another: the market power of providers.¹⁶ As the Medicare Payment Advisory Commission noted, “[o]ne key driver of higher prices in the United States is provider market power. Hospitals merge and physician groups consolidate to gain market power over insurers to negotiate higher payment rates.”¹⁷ Such power is a pervasive feature of healthcare markets, enabling many hospitals, physician groups, and manufacturers of patented drugs to charge more or provide less than a competitive market would permit.¹⁸

At the same time, the market power of providers is limited by power on the other side of the market— by buyer power.¹⁹ Differences in buyer power help explain why Americans pay higher prices for healthcare than consumers in other developed countries. As Reinhardt, Hussey, and Anderson point out, in some countries, all healthcare purchases are made by a single buyer (the government); in others, there are multiple purchasers but they are allowed to bargain collectively; and both techniques yield lower prices than the American system, which utilizes multiple payers in both the public sector (e.g., Medicare and Medicaid) and the private (e.g., insurance companies and employers).²⁰

Consumers, N.Y. TIMES, Oct. 5, 2015, at A1; see also Joseph Walker, *Price Increases Drive Drug Firms' Revenue*, WALL ST. J., Oct. 6, 2015, at A1 (“For 20 leading global drug companies last year, 80% of growth in net profits stemmed from price increases in the U.S., according to a May report by Credit Suisse.”).

15. See HENRY J. AARON, *SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE* 9, 25, 48–49 (1991); EMANUEL, *supra* note 2, at 39, 89, 115.

16. Market power is the “ability to price profitably above the competitive level.” DENNIS W. CARLTON & JEFFREY M. PERLOFF, *MODERN INDUSTRIAL ORGANIZATION* 8 (3d ed. 2000).

17. MEDPAC, *supra* note 1, at 28.

18. See *infra* Parts I & II.

19. Buyer power is the “ability of a buyer to depress the price it pays a supplier or obtain more favorable nonprice terms.” John B. Kirkwood, *Powerful Buyers and Merger Enforcement*, 92 B.U. L. REV. 1485, 1493 (2012).

20. See Reinhardt et al., *supra* note 2, at 13.

[M]ultiple purchasers of care allow U.S. prices to rise above the level attained in other industrialized countries that either endow the demand side of their health systems with strong, monopsonistic (single-buyer) market power (such as the Canadian provincial health plans) or allow multipayer systems to bargain collectively with the providers of health care, sometimes within government-set overall health care budgets (as, for example, in Germany).

Differences in buyer power are also critical to understanding why different categories of purchaser (or third-party payer) are charged different prices for the same product or service.²¹ Consider prescription drugs, where price discrimination is endemic. The federal government obtains the lowest prices when it buys for the Department of Defense (DOD) or the Department of Veterans Affairs (VA).²² Uninsured consumers pay the highest prices, since they must pay cash and have no buyer power at all.²³ In between are health plans and self-insured employers, who exert varying degrees of leverage, depending on their size and the market power of the drug.²⁴ Professor Reinhardt concludes: “[t]oday’s system of price discrimination in US health care . . . appears to reflect mainly the relative bargaining power . . . of those who pay for health care and those who provide it.”²⁵

This pattern, both internationally and within the United States, suggests that America ought to take greater advantage of buyer power. By allowing buyers to combine, or letting the biggest buyer of all, the federal government, play a larger role in setting national healthcare prices, the country could reduce healthcare costs and achieve all the benefits that would entail, including greater access to services, lower federal budget deficits,²⁶ higher wages and salaries,²⁷ and fewer

Id.

21. See Richard G. Frank, *Prescription Drug Prices: Why Do Some Pay More than Others Do?*, 20 HEALTH AFF. 115, 121 (2001) (noting that price differentials “represent unequal bargaining power across different classes of purchasers”).

22. See *id.* at 117 (“The federal supply schedule and the prices negotiated off of that schedule by the Department of Veterans Affairs (VA) and the Defense Department tend to be the lowest prices in the land (58 percent of the cash/drugstore price).”).

23. *Id.* (“Cash payers pay the highest prices.”); see also Brill, *supra* note 1 (“If you are confused by the notion that those least able to pay are the ones singled out to pay the highest rates, welcome to the American medical marketplace.”).

24. See Frank, *supra* note 21, at 117 (“Institutional buyers . . . realize price concessions from manufacturers of 5–30 percent of the amount paid by cash payers.”).

25. See Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2129 (2011).

26. Many commentators have emphasized that, if federal spending on healthcare continues to increase, it will lead to unsustainable budget deficits, crowd out spending on other national priorities, or both. See, e.g., Ezekiel Emanuel et al., *A Systemic Approach to Containing Health Care Spending*, 367 NEW ENG. J. MED. 949, 949 (2012).

National health spending is projected to continue to grow faster than the economy, increasing from 18% to about 25% of the gross domestic product (GDP) by 2037. Federal health spending is projected to increase from 25% to approximately 40% of total federal spending by 2037. These trends could squeeze out critical investments in education and infrastructure [and] contribute to unsustainable debt levels

Id.; see also MEDPAC, *supra* note 1, at 3 (“If [healthcare] spending continues to consume an

instances of extreme financial hardship.²⁸ Indeed, the country could maximize the benefits of buyer power by moving to a “single payer” system, in which the federal government is the sole purchaser of healthcare goods and services for the entire population.

But buyer power is a double-edged sword. By depressing provider prices, a large buyer could reduce the incentives of providers to enter the market, to develop new treatments, or to maintain quality, harming rather than benefiting consumers.²⁹ By inducing *discriminatory* prices from suppliers, a large buyer could gain a competitive advantage over smaller rivals, weaken or destroy them, and then raise prices or limit choice.³⁰ Likewise, if two buyers merge to gain more buyer power, they may also acquire market power as *sellers*, diminishing competition downstream and harming consumers.

This Article examines whether greater buyer power is desirable for consumers in two major sectors of the healthcare industry. The first, prescription drugs covered by Medicare, is the subject of Part I. Currently, the federal government is prohibited from using its considerable purchasing leverage to obtain lower prices from drug manufacturers. Part I asks whether this ban on federal negotiation should be repealed, as both President Obama and Hillary Rodham Clinton have proposed.³¹ Part II turns to hospitals and physicians covered by private insurance and asks whether insurance companies ought to be allowed to merge so they can bargain more effectively with these providers. As

increasing share of federal and state budgets, spending for other public priorities . . . will be crowded out”); Richard G. Frank & Joseph P. Newhouse, *Should Drug Prices Be Negotiated Under Part D of Medicare? And If So, How?*, 27 HEALTH AFF. 33, 36 (2008) (“[T]he growth of Medicare and Medicaid will continue to place enormous strains on the budget.”).

27. See Emanuel et al., *supra* note 26, at 949 (finding that future increases in healthcare spending could “constrain wage increases for the middle class”).

28. Reinhardt, *supra* note 25, at 2129 (“Today’s system . . . can saddle uninsured middle-class Americans, who have the least bargaining power, with very high prices and great financial hardship.”).

29. In healthcare, these harms—to quality, choice, or innovation—are not just pocketbook matters.

30. According to the chief antitrust economist at the Department of Justice, the Antitrust Division staff opposed the Comcast/Time Warner Cable merger in significant part because it would have compounded the parties’ ability to induce such discriminatory advantages. See Jeff Bliss, *Large Cable Companies’ Contract Terms Helped Turn DOJ Against Comcast-TWC*, *Agency Economist Says*, MLEX, June 15, 2015.

31. See David Morgan, *Obama Administration Seeks to Negotiate Medicare Drug Prices*, REUTERS (Feb. 2, 2015), <http://www.reuters.com/article/2015/02/02/us-usa-budget-medicare-idUSKBN0L61OW20150202> [<https://perma.cc/DY33-JB2C>]; Sarah Kliff, *After Obamacare, Democrats Turn to Prescription Drug Prices as Health-Care Priority*, VOX (Sept. 22, 2015, 6:10 AM), <http://www.vox.com/2015/9/22/9368489/clinton-drug-prices> [<https://perma.cc/5C8E-MJEC>].

many commentators have noted, this could benefit consumers by forcing hospitals and physician groups with market power to lower their prices.³²

In brief, my conclusions are the following:

Federal Negotiation. Congress ought to allow the federal government to negotiate the prices of prescription drugs provided by Medicare. To make those negotiations effective, the federal government should have the power to exclude drugs from the program, or cover them less favorably, if the manufacturer fails to offer a substantial discount. This process would substantially reduce the cost of many patented, brand name drugs and save taxpayers and consumers billions of dollars a year, as experience in Europe and with federal procurement in the United States indicates. But the step would not be cost free. By lowering the profitability of many of these drugs, it would reduce the incentive to develop them. This effect is unlikely to be large, however, because the federal government funds most basic scientific research, the incentive to develop unique and important new drugs would remain high because the government would have little leverage over their prices, and branded drug makers appear to have been exceptionally profitable in recent years. If so, many drug prices could be lowered without depriving the drug makers of a competitive return on most research and development (R&D) projects. Moreover, if problems do develop with new drug development, payments could be increased.

Mergers of Insurance Companies. Some combinations of health insurers may be procompetitive. By merging they can enlarge their countervailing power as buyers and force hospitals and physician groups with market power to lower their prices. And if the downstream market remains competitive, the merged firm is likely to pass on these savings in the form of lower co-payments and lower premiums. But a merger that is large enough to increase buyer power significantly may harm competition in multiple ways. First, it may create monopsony power and enable the merged firm to exploit small, competitive providers.³³ Second, the merger may create downstream market power, which could offset the desirable effects of countervailing power and raise premiums

32. See, e.g., Victor R. Fuchs & Peter V. Lee, *A Healthy Side of Insurer Mega-Mergers*, WALL ST. J., Aug. 27, 2015, at A13 (“The greater efficiency and market power of larger insurance plans could lower prices for consumers by offsetting the bargaining power of health-care providers.”); Anna Wilde Mathews & Christopher Weaver, *Health Mergers Could Cut Consumer Options*, WALL ST. J., June 22, 2015, at A1 (“Many experts have said that [mergers of hospitals] can drive higher rates—and that more-powerful insurers might have a better chance of countering them and striking facts for new forms of payment that incentivize efficiency.”).

33. Monopsony power is the “ability to profitably set wages (or other input prices) below competitive levels.” CARLTON & PERLOFF, *supra* note 16, at 106.

to consumers. Finally, the merger might create countervailing power, but the merged firm might exercise it in anticompetitive ways, harming consumers or small providers.³⁴ Because a merger of large insurance companies is likely to present one or more of these competitive risks, allowing these mergers is not a promising way of lowering healthcare costs.

I. FEDERAL NEGOTIATION OF MEDICARE PRESCRIPTION DRUG PRICES

When the federal government purchases prescription drugs for the DOD or the VA, it determines the prices it will pay for these drugs by negotiating with pharmaceutical manufacturers.³⁵ But when drugs are procured for Medicare, a much larger program with much larger consequences for the federal budget, the government plays no role in setting prices. Congress has prohibited the federal government from negotiating Medicare prescription drug prices.³⁶ This Part of the Article examines that controversial prohibition. It first reviews the dynamics of current pricing and then assesses the advantages and disadvantages of allowing the federal government to wield its purchasing power.

The Article focuses on patented brand name drugs because they are the most expensive prescription drugs sold in the United States. Generic drugs, by contrast, are generally much cheaper. Indeed, it may be fair to say that there are two drug industries in this country. In the first, made up of patented branded drugs, prices are determined not by the cost of producing or developing a drug, but by the therapeutic advantage of a drug relative to other drugs on the market. Over time, this value-based pricing has led to high and rising charges for new brand name drugs. In the second industry, made up of generic drugs, prices are determined primarily by the number of producers and their costs. As additional producers enter the market for a particular generic, prices are driven closer to marginal cost. With relatively free entry, that has meant low

34. As this summary suggests, it is important in analyzing buyer power to distinguish monopsony power from countervailing power. Monopsony power is the kind of power that a dominant buyer exerts against small, *competitive* suppliers. Countervailing power, in contrast, is the kind of power that a substantial buyer exercises against suppliers *with market power*. The distinction is significant because the two types of power frequently have different effects, with monopsony power (unless justified as a reward for superior performance) generally harmful, and countervailing power usually—but not always—beneficial. For a more detailed explanation, see *infra* note 43.

35. See *infra* notes 65–66.

36. See *infra* Section I.A.1.

prices for the typical generic drug.³⁷

A. Current Pharmaceutical Pricing Under Medicare

1. Prohibition on Federal Negotiation

Congress has barred the federal government from exerting its buyer power to procure cheaper prescription drugs for Medicare. Instead, “Medicare is a price taker: the price is set by the drug companies, and Medicare has no flexibility or negotiating power to pay a lower price.”³⁸ Congress has achieved this result in two ways. Under Medicare Part B, which covers physician visits and other nonhospital services, the price for drugs administered in a doctor’s office is determined by the average sales price in the previous quarter.³⁹ In essence, what drug companies charged the prior quarter determines what they can charge this quarter. Under Medicare Part D, the much larger and more general prescription drug benefit, prices are fixed through negotiations between private prescription drug plans (PDPs) and drug manufacturers. The federal government cannot interfere with this process.⁴⁰ In neither Part B nor Part D, therefore, can the government wield its bargaining leverage, threatening to withhold or limit purchases in order to obtain lower prices.

In contrast, as the following Section explains, PDPs regularly utilize

37. I am indebted to Professor Comanor for this description of the prescription drug sector. For two of his significant contributions, see Z. John Lu & William S. Comanor, *Strategic Pricing of New Pharmaceuticals*, 80 REV. ECON. & STAT. 108 (1998); William S. Comanor & F.M. Scherer, *Mergers and Innovation in the Pharmaceutical Industry*, 32 J. HEALTH ECON. 106 (2013). As Comanor and Scherer stress, generic drug use has grown enormously in the last three decades. *See id.* at 106 (“Generic fulfillment of prescriptions has risen from 17 percent in 1980 and 30 percent in 1990 to upwards of 70 percent by number in 2009.”). Competition in the generic industry, moreover, has given the United States the lowest generic prices in the world. *See* Patricia M. Danzon & Michael F. Furukawa, *International Prices and Availability of Pharmaceuticals in 2005*, 27 HEALTH AFF. 221, 232 (2008).

38. EMANUEL, *supra* note 2, at 60 (referring to Medicare Part B); *see also* Thomas F. Cotter, *Patents, Antitrust and the High Cost of Health Care*, ANTITRUST SOURCE, Apr. 2014, at 1, 9–10 (“Congress has specifically forbidden Medicare from negotiating favorable prices for prescription drugs in the manner of national health services elsewhere.” (referring to Medicare Part D)).

39. *See* EMANUEL, *supra* note 2, at 60; Whalen, *supra* note 5 (“The arrangement means Medicare is essentially forfeiting its buying power, leaving bargaining to doctors’ offices that have little negotiating heft, said Sean Sullivan, dean of the School of Pharmacy at the University of Washington.”).

40. *See* 42 U.S.C. § 1395w-111(i) (2012) (“[T]he Secretary . . . (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.”).

their buyer power to induce discounts from the drug companies. Moreover, the discounts they have obtained are significant, even though no plan commands the volume of business the federal government would control if it were the sole purchaser of prescription drugs for Medicare.

2. *Price Reductions from Private Plan Negotiations*

As noted, Medicare relies on private insurance companies to provide its general prescription drug benefit (Part D). Instead of assigning drug procurement to the government, as other developed countries do, Medicare allows private plans to decide which drugs to cover (subject to significant exceptions) and how much to pay for them. To keep premiums down, Medicare subsidizes these PDPs.⁴¹ The plans compete among themselves to sell coverage to seniors and try to reduce their costs (and the payments of their subscribers) by negotiating better deals with pharmaceutical manufacturers.⁴²

The prime method they use to negotiate better deals is the method that large buyers have long used to extract concessions from a supplier with market power: they promise to bring additional business if the supplier cuts price or threaten to withhold business if it refuses.⁴³ This method

41. See Mark Duggan & Fiona Scott Morton, *The Effect of Medicare Part D on Pharmaceutical Prices and Utilization*, 100 AM. ECON. REV. 590, 591 (2010) (“Governments outside the United States use their power as large buyers to pay relatively low prices for new, patent-protected medications. In contrast, Part D is set up so that the government does not directly purchase drugs, but rather subsidizes participating private prescription drug plans.”).

42. See *id.*

43. See, e.g., Frank & Newhouse, *supra* note 26, at 35 (“[T]he drug insurance plan can obtain a favorable price by steering purchasing volume to particular products over others in response to manufacturers’ price offers.”). When a substantial buyer obtains a discount from a supplier with market power by playing that supplier off against other suppliers, the buyer is exerting *countervailing* power, not *monopsony* power. For a discussion of the two types of buyer power, describing their nature, prerequisites, and effects, see Kirkwood, *supra* note 19, at 1493–1512.

In brief, monopsony power is the classic form of buyer power, modeled in economic textbooks as the mirror image of monopoly power. In the textbook monopsony model, a single buyer purchases from atomistically competitive suppliers, each without market power and each producing on an upward-sloping marginal cost curve. The monopsonist maximizes its profits by depressing its purchase price below the competitive level and the suppliers respond by reducing their output. See *id.* at 1495–1500.

In contrast, countervailing power is the type of buyer power that is wielded against a supplier with market power. In response, the supplier frequently lowers its price closer to the competitive level, which often causes the buyer to lower its price as well, increasing output and benefiting consumers. But the exercise of countervailing power is not always procompetitive. There are many ways in which it could harm consumers and several ways in which it could result in the creation of monopsony power and the exploitation of powerless suppliers. See *id.* at 1500–12. These two types of buyer power are polar models and neither type may fit a particular market exactly. But it is highly useful, in analyzing buyer power, to be aware of the two types, for the effects of buyer power may

works with brand name prescription drug makers because they typically exercise market power. Their branded drugs are differentiated from other drugs, sometimes sharply, while they remain on patent.⁴⁴ Moreover, even when their patented drugs face relatively close substitutes, they often face just a few.⁴⁵ As a result, the manufacturer can price them above marginal cost, sometimes far above marginal cost. Indeed, brand name pharmaceuticals are a well-known example of a high fixed cost, low marginal cost industry, with high fixed costs of research and development, and low marginal costs of production.⁴⁶

With this cost structure, a manufacturer is vulnerable to a large buyer that can make a credible commitment to move business in response to the manufacturer's pricing. Suppose, for example, that the buyer promises to bring additional business if the manufacturer lowers its price on that business. If this promise is credible, the manufacturer is likely to accede, so long as the lower price is above marginal cost, because the additional business would increase its profits. Suppose, instead, that the buyer threatens to withdraw its existing business unless the manufacturer lowers its price. If this threat is credible, the manufacturer is likely to cut the price, assuming the lower price is above marginal cost, since it makes more sense to accept a reduction in profits than lose *all* the buyer's business.

The principal device that health plans use to move business is a formulary. This is simply a list of the drugs that a plan covers, but it is an effective tool for bringing business to or removing business from a drug manufacturer. By adding a drug to its formulary, a PDP can

differ considerably depending on whether the power is exerted against small suppliers pricing competitively or large suppliers with market power. *See id.* at 1495 n.34.

44. This differentiation is greatest where a drug has no therapeutic substitutes. *See infra* notes 58–60 and accompanying text (indicating that drugs with no substitutes command higher prices).

45. Moreover, a prescribing doctor may give little weight to price in deciding which of a group of patented drugs to choose for a patient, further reducing each manufacturer's incentive to cut price.

46. *See* Frank & Newhouse, *supra* note 26, at 34 (“Most prescription drugs can be produced for ‘pennies a pill,’ but developing new and important pharmaceutical agents is a costly, time-consuming, and risky enterprise requiring a substantial up-front investment of capital.”); Joseph P. Newhouse, *How Much Should Medicare Pay for Drugs?*, 23 HEALTH AFF. 89, 92 (2004) (“The industry’s fixed costs are high relative to its marginal costs Once production begins, the marginal cost of producing another pill is typically negligible.”).

Given this cost structure, incremental sales are highly profitable, which creates a powerful incentive to generate additional sales. As a result, “incentives to invest heavily in marketing are substantial, something for which pharmaceutical manufacturers are notorious.” Ernst R. Berndt et al., *A Primer on the Economics of Prescription Pharmaceutical Pricing in Health Insurance Markets*, F. FOR HEALTH ECON. & POL’Y, Nov. 2011, at 1, 3 n.6. Indeed, it is common to note that brand name drug manufacturers spend more on marketing than they do on R&D.

increase the manufacturer's sales of that drug. By removing a drug, the plan can reduce the manufacturer's business, sometimes sharply.⁴⁷ Today, plans are increasingly using tiered formularies, in which lower tiers offer lower co-payments.⁴⁸ Since lower co-pays reduce the out-of-pocket costs a consumer incurs, they generally lead to greater sales.⁴⁹ As a result, the negotiations between a PDP and a drug company are not only over whether a drug should be listed on the formulary but what tier it should be on.⁵⁰

Government regulations limit this bargaining in an important way. Rules issued by the Centers for Medicare and Medicaid Services (CMS) require PDPs to cover at least two drugs in every therapeutic category and, in certain categories, to cover essentially all drugs.⁵¹ In those six, all-inclusive categories, a PDP cannot threaten to drop a drug from its formulary if the manufacturer refuses to provide a discount. The plan can only threaten to move the drug to a higher tier.⁵² This significantly reduces the plan's bargaining leverage.⁵³

Where PDPs can remove a drug from their formulary, they have been able to obtain significant discounts, even though no PDP has the leverage the federal government would have if it were the sole purchaser of prescription drugs for Medicare. Two studies have demonstrated the buying power of these private plans. Professors Duggan and Morton

47. See, e.g., *infra* note 61.

48. See Charles Orenstein, *Those Rising Co-Payments for Prescription Drugs*, N.Y. TIMES, Aug. 31, 2014, at B6 ("Insurance plans with multiple cost tiers have become more prevalent in recent years. . . . By 2013 . . . more than eight in 10 workers had private insurance plans with three or more tiers of drug prices.").

49. Berndt et al., *supra* note 46, at 15 ("[L]ower patient copayments increas[e] the quantity demanded of the drug."); see also *id.* at 20 ("The insurer increases its bargaining power by limiting the number of preferred brands, and by lowering the copayment for the preferred tier. Each of these contribute to its power to 'move market share' to the preferred drug.").

50. See *id.* at 15 (noting that "if the manufacturer insists on a high drug price it risks banishment to the third tier, where patients have the largest copayment, or not even being on the formulary, in which case the consumer pays the entire price out-of-pocket").

51. MEDPAC, *supra* note 1, at 381 ("For most drug classes, CMS requires plan formularies to cover—in every therapeutic class and key drug type—at least two drugs that are not therapeutic substitutes, unless only one drug is approved for that class. . . . For six drug classes, CMS requires Part D plans to cover 'all or substantially all' drugs in the class."). These requirements benefit consumers by broadening the number of covered drugs. As the text explains, however, they also tend to raise the prices that PDPs and consumers pay.

52. See *id.* Plans can also try to limit use of these drugs through prior authorization requirements or step therapy. Duggan & Morton, *supra* note 41, at 603.

53. See Duggan & Morton, *supra* note 41, at 603 ("The ability to exclude [drugs] from the formulary provides . . . potentially important leverage . . ."). Thus, while the CMS requirements give consumers a broader choice of drugs, they come at a significant cost.

found that during the first year of Part D's operation, the prices of drugs used principally by Medicare recipients "declined by approximately 10 percent in real terms while those for other consumers increased by 12 percent."⁵⁴ As the authors note, these results "strongly suggest that Part D plans have succeeded in negotiating lower price increases for Part D enrollees—approximately 20 percent lower than they otherwise would have been."⁵⁵ Likewise, the Medicare Payment Advisory Commission (MEDPAC) found that where PDPs could exercise their purchasing leverage, they obtained substantial savings. Looking at the six-year period from 2006 through 2011, MEDPAC reported that the prices for multisource brand name drugs increased 44% whereas prices for single source brand name drugs increased 66%.⁵⁶ This twenty-two point difference represents the difference between cases in which PDPs could play suppliers off against each other and cases in which they could not.⁵⁷

As this result suggests, neither study uncovered substantial price effects when it focused on drugs that a PDP could not exclude from its formulary, either because the drug had no substitute or because all the drugs in a therapeutic category had to be covered. Duggan and Morton state: "Our analyses show that prices do not decline in relative terms for brands with zero or only one substitute in a class."⁵⁸ Moreover, as just noted, MEDPAC found that single-source brand name drugs experienced substantially higher price increases than multisource brand name drugs.⁵⁹ The Commission stated: "the prices for unique drugs and biologics have grown rapidly. Because those products lack clear substitutes, [PDPs] have little leverage for price negotiations."⁶⁰

In short, where three or more branded drugs are therapeutic substitutes, PDPs have been able to negotiate significant discounts. But where the upstream market structure is a monopoly or duopoly, private plans have exerted little power.

54. *Id.* at 602.

55. *Id.* at 605.

56. See MEDPAC, *supra* note 1, at 384 fig.14-6.

57. See *id.*

58. Duggan & Morton, *supra* note 41, at 592 (noting that PDPs were "required to cover all drugs in small classes").

59. See *supra* note 56 and accompanying text.

60. See MEDPAC, *supra* note 1, at 362–63; Frank & Newhouse, *supra* note 26, at 37 ("In the case of prescription drugs without good substitutes, PDPs are in a weak bargaining position . . .").

B. *Federal Negotiation of Medicare Drug Prices*

If the federal government were the sole purchaser of prescription drugs for Medicare, it would control much more business than any single PDP now commands, enabling it to wield much greater buyer power and, where substitutes are available, obtain substantially lower prices. At the same time, though, these lower prices, or the tactics used to obtain them, could have significant adverse effects. They could reduce the variety of drugs available to Medicare beneficiaries or the number of new drugs introduced. The following Sections address the impact of federal negotiation of Medicare prescription drug prices on price levels, choice of drugs, and new drug development.⁶¹

1. *Price Levels*

If the government could establish a single Medicare formulary and credibly threaten to exclude particular drugs from that formulary, it is likely to obtain discounts that exceed, by a substantial margin, what PDPs now negotiate. Two principal reasons support this conclusion. First, the prices of brand name drugs are much lower in other developed countries than they are in the United States,⁶² principally because governments in those countries negotiate or set prices.⁶³ Since Medicare is larger than the entire health sectors of many countries,⁶⁴ the U.S. government is likely to exert at least as much buyer power. Second, when the federal government purchases drugs for a major program, as it does for the DOD and VA, it receives the cheapest prices in the country.⁶⁵ Indeed, drugs procured for DOD and VA are often priced 15%

61. Federal negotiation of Medicare prescription drug prices could have other adverse effects. It could raise the administrative costs of procuring prescription drugs for Medicare or, because the federal government is more subject to political influence than private health plans, it could reduce the efficiency of the program. While a thorough exploration of both issues is beyond the scope of this Article, neither possibility appears to pose a serious obstacle. No article, white paper, or other source reviewed for this Article contended that the administrative costs of federal negotiation would be high or that political influence would undermine the value of the program.

62. See Nicole Woo & Dean Baker, *State Savings with an Efficient Medicare Prescription Drug Benefit*, CTR. FOR ECON. & POL'Y RES. ISSUE BRIEF, Mar. 2013, at 1 (“Canada spends a bit over 70 cents for each dollar spent in the United States per person on prescription drugs. The United Kingdom spends just under 40 cents, and Denmark only about 35 cents.”); *supra* note 5 and accompanying text.

63. Woo & Baker, *supra* note 62, at 1 (“The reason that other countries spend so much less on drugs is that their governments negotiate prices with the pharmaceutical industry.”).

64. *Id.* (“Medicare . . . also provides a huge market, actually far larger than many other countries.”).

65. See Frank, *supra* note 21, at 117 (“The federal supply schedule and the prices negotiated off

to 60% below their Part D prices.⁶⁶

To be sure, the pharmaceutical manufacturers would resist such a major threat to their profits and attempt to compensate by reducing the discounts they offer to health plans in the private sector.⁶⁷ Such cost shifting, however, is unlikely to eliminate the gains to consumers from federal negotiation. Studies of cost shifting by hospitals have found that they generally recover part of their losses from lower Medicare reimbursements by raising prices to private payers, but the offset is nowhere near complete.⁶⁸ It seems fair to predict, therefore, that on many drugs the federal government would be able to obtain discounts that substantially exceed what PDPs now extract, though a portion of these price reductions would be wiped out by higher prices in the private sector.⁶⁹

of that schedule by the Department of Veterans Affairs (VA) and the Defense Department tend to be the lowest prices in the land (58 percent of the cash/drugstore price).”)

66. See *id.* at 122 (by limiting the number of drugs it covered, the VA secured “price concessions of 16–41 percent below the federal price that already was among the lowest in the nation”); GAGNON & WOLFE, *supra* note 5, at 11 (noting that “on average, a brand-name drug that costs \$83 under Medicare Part D would cost \$48 under Medicaid and \$46 under [VA]”); Walid F. Gellad et al., *What If the Federal Government Negotiated Pharmaceutical Prices for Seniors? An Estimate of National Savings*, 23 J. GEN. INTERNAL MED. 1435 (2008) (“A report by Families USA, which looked at the top 20 drugs prescribed to seniors, found that VA prices were substantially lower than the cheapest Part D plans, with a median price difference of 58%.”).

67. See Gellad et al., *supra* note 66, at 1439 (noting that drug manufacturers would likely react to lower Medicare prices “with higher prices for cash-paying customers and private health plans”); Ezekiel J. Emanuel, *The Solution to Drug Prices*, N.Y. TIMES, Sept. 9, 2015, at A31 (same).

68. See, e.g., Austin Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 92 (2011) (indicating that cost shifting occurs, though far below dollar-for-dollar levels); Vivian Y. Wu, *Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997*, 10 INT’L J. HEALTH CARE FIN. & ECON. 61 (2010) (finding that cost shifting from Medicare to private payers is lower in markets with a greater proportion of for-profit hospitals, but overall about twenty-one percent of Medicare payment reductions are shifted to private payers); see also Kirkwood, *supra* note 19, at 1545 n.243 (describing additional studies).

69. As Emanuel points out, the government would not have to worry about cost shifting if it set prescription drug prices for the *entire* health care sector, not just Medicare. See Emanuel, *supra* note 67. But such a step, which would bring the nation closer to a single-payer model, would pose considerably greater risks to consumer choice and innovation. Thus, while single payer may be the ultimate solution, it seems prudent to move incrementally at first and see how that works out before greatly expanding the government’s role.

Likewise, it seems unwise to apply the Medicaid approach to Medicare—that is, require the prescription drug makers to provide fixed rebates on all drugs furnished to Medicare, as they are required to do for Medicaid. While this would produce lower prices, see Robert Pear, *Medicaid Pays Less than Medicare for Many Prescription Drugs*, U.S. REPORT FINDS, N.Y. TIMES (Aug. 15, 2011), <http://www.nytimes.com/2011/08/16/us/16drug.html>, it would also pose significant dangers to innovation. If the rebates were set too high, they would deprive drug makers of an adequate return on the vast bulk of their R&D. Fixed rebates, moreover, would not enable the government to provide greater rewards to more important therapeutic advances. In contrast, federal negotiation

The federal government's leverage would be much more limited on drugs that are the only treatment in a therapeutic category. As noted above, PDPs have been unable to induce significant discounts on such drugs.⁷⁰ While the federal government could threaten to place a sole-source drug on a higher tier of its formulary, private plans do that now with relatively little effect. Total exclusion from the formulary has much greater impact. As officials at Sloan Kettering and Express Scripts have observed, it is the ability to deny coverage altogether—to say no to a particular drug—that produces the greatest discounts.⁷¹ If the federal government cannot say no to a drug because it is the only cure for a serious disease, it is unlikely to obtain any significant price reduction. Indeed, as Professor Newhouse has pointed out, if the federal government cannot say no, the manufacturer may charge “an abusive supply price.”⁷²

In sum, federal negotiation of prescription drug prices for Medicare is likely to produce substantial discounts on drugs that face multiple substitutes. This would save the government—and taxpayers—billions of dollars a year,⁷³ though these savings would be partly offset by cost shifting to private payers. In contrast, where a drug has no therapeutic substitute, the government could not exclude it from its formulary. The government might be able to assign the drug to a higher tier, or limit coverage to patients with a proven need for it, but it could not, in today's

would automatically do so, since, as explained below, the more important and unique the new drug, the less leverage the government would have over its price. These reasons help explain why federal negotiation of prescription drug prices is preferable, at least initially, to federal regulation of drug prices.

70. See *supra* notes 58–60 and accompanying text.

71. See Peter B. Bach, *Why Drugs Cost So Much*, N.Y. TIMES, Jan. 15, 2015, at A25 (stating that European countries have achieved major price reductions by saying “no to a handful of drugs each year,” that “[s]aying no, or even the threat, works to lower prices in the United States, too,” and that after Sloan Kettering refused to give Zaltrap to its patients, the manufacturer “halved its price nationwide”); Andrew Pollack, *Health Insurers Are Pushing Back on Drug Prices*, N.Y. TIMES, June 21, 2014, at A1, A3 (finding that after Express Scripts excluded Advair from its formulary, its “sales in the United States plummeted 30 percent in the first quarter, while sales of AstraZeneca's Symbicort, a rival that remained on the formulary, grew 20 percent”).

72. Newhouse, *supra* note 46, at 92. As Newhouse points out, Congress could reduce this problem by requiring compulsory arbitration of the prices of major, new, sole-source drugs. See *infra* Section I.C.

73. See GAGNON & WOLFE, *supra* note 5, at 11 (“If Medicare Part D benefited from the same discounts as [VA], it would have saved \$16 billion a year [in 2010].”); Gellad et al., *supra* note 66, at 1435 (Medicare would save about \$22 billion a year in 2006 prices if it paid no more for its top 200 drugs than DOD and VA pay); Woo & Baker, *supra* note 62, at 1 (“[T]he federal government could save from \$230 billion to \$541 billion over the next ten years if Congress and the President were to enable Medicare to negotiate prescription drug prices.”).

political environment, threaten to deny coverage altogether.⁷⁴ As a result, the discount on such a drug is likely to be modest at best and its price is likely to be very high.

2. *Choice of Drugs*

If the federal government negotiated prescription drug prices for Medicare and used its formulary aggressively, threatening to exclude any drug with a substitute if its price were too great, the result could be a very narrow formulary.⁷⁵ In each therapeutic category there might be only one option. Such a severe restriction on consumer choice is unlikely, however, for two reasons. First, suppose that several drugs are substitutes for most patients and the government has excluded all but one of them from its formulary. If some patients nevertheless need an excluded drug—if, for them, the drug on the formulary does not provide an adequate treatment—they could be given the right to appeal the exclusion, as Part D now provides.⁷⁶ In short, for patients that require a drug, their choice need not be restricted. Second, the government does not have to exclude many drugs from its formulary in order to obtain substantial discounts. The mere threat of exclusion may be enough to convince a manufacturer to reduce its price. In other words, if there are three substitutes in a therapeutic category, and the government is willing to exclude any two of them if their prices are not cut, all three may offer a significant discount in order to avoid exclusion. For this reason, European countries have been able to offer their citizens *both* low prices

74. This would not be the case if Congress allowed Medicare to ration care—to refuse to cover even a life-saving drug if, for example, the number of beneficiaries was tiny and the price of the drug was astronomical. But at the moment, this form of cost-effectiveness calculation is politically unacceptable. See Frank & Newhouse, *supra* note 26, at 39 (“In the Medicare context, there will surely be strong political pressure not to allow PDPs to leave unique (and presumably superior) products off the formulary.”); Robert Pear, *White House Withdraws Plan Allowing Limits to Medicare Coverage for Some Drugs*, N.Y. TIMES, Mar. 11, 2014, at A13 (“Under pressure from patients, pharmaceutical companies and members of Congress from both parties, the Obama administration . . . withdrew a proposal that would have allowed insurers to limit Medicare coverage for certain classes of drugs; [while] the proposal would have saved money . . . it created political problems for the White House.”).

75. At present, as noted earlier, PDPs must cover at least two drugs in every therapeutic category, and in six categories they must cover all or substantially all the drugs in the category. See *supra* note 51 and accompanying text. To maximize the government’s ability to obtain discounts, these restrictions should be eliminated. As explained below, however, increasing the government’s ability to threaten to exclude a drug from its formulary does not mean it will actually be excluded.

76. See MEDPAC, *supra* note 1, at 367 (“Plans are required to establish exceptions and appeals processes to ensure that their formularies do not impede access to needed medications.”). The existing processes appear to be “complex and burdensome for many individuals,” however, and MEDPAC has recommended “increased transparency and streamlining.” *Id.* at 367, 369.

and broad formularies.⁷⁷

In short, while federal negotiation may result in some narrowing of consumer choice, the overall impact is unlikely to be large. No patient would be denied a needed medicine and most patients are likely to have multiple options. The impact of federal negotiation on innovation would be similar: there would be some adverse effect but it is unlikely to be large.

3. *New Drug Development*

If the federal government takes over the procurement of prescription drugs for Medicare, it is likely that pharmaceutical R&D would decline. Because the government would obtain greater discounts on many drugs than PDPs now achieve, the average return on developing a new drug is likely to fall, and the companies are likely to engage in less of this activity. As many economists have noted, a rational pharmaceutical manufacturer would not invest in R&D unless the investment is expected to be profitable.⁷⁸ If the average price of a new drug were to decline, then R&D projects at the margin—those that are just profitable at existing prices—would no longer be undertaken. While we do not know the exact size of this effect, we do know that Medicare Part D led to an increase in R&D.⁷⁹ Since Part D increased the demand for prescription drugs, this suggests a direct link between profitability and R&D.⁸⁰

Despite this link, it does not appear that federal negotiation would have a large impact on pharmaceutical innovation. Multiple studies suggest that branded drug manufacturers have been exceptionally

77. See Bach, *supra* note 71.

A recent survey of cancer drug policies revealed you don't have to say no very often to get discounts for saying yes. Of the 29 major cancer drugs included in the study that are available in the United States, an estimated 97 percent and 86 percent are also available in Germany and France [at much lower prices] respectively.

Id.

78. See, e.g., Blair & Durrance, *supra* note 4, at 4 (“For an investment in a pharmaceutical R&D project to make economic sense, it must have a reasonable expectation of profits.”); Newhouse, *supra* note 46, at 92 (“R&D requires capital, and a manufacturer will not obtain or invest that capital unless it can, on a probabilistic basis, obtain a return at least equal to the capital's next best use.”).

79. See Margaret E. Blume-Kohout & Neeraj Sood, *Market Size and Innovation: Effects of Medicare Part D on Pharmaceutical Research and Development*, 97 J. PUB. ECON. 327, 334 (2013).

80. Moreover, R&D increased the most in protected drug classes—the classes where PDPs have little power to negotiate discounts and where, as a result, the greatest increase in profitability occurred. See *id.*; William S. Comanor, *The Economics of Research and Development in the Pharmaceutical Industry*, in PHARMACEUTICAL INNOVATION 54, 71 (F. Sloan & C.R. Hsieh eds., 2007) (noting that a 2005 study found that a ten percent increase in real drug prices was associated with nearly a six percent rise in R&D intensity).

profitable in recent years.⁸¹ If this is correct, then even if marginal R&D projects became unprofitable, most projects would remain worthwhile. Put differently, if the industry has consistently earned high profits, despite the high failure rate of new drugs,⁸² then its overall, risk-adjusted return on investment has been above the competitive level. If so, the profitability of many drugs could be reduced significantly without depriving the industry of a competitive return on most R&D.

In addition, profits are unlikely to fall significantly on drugs that have no substitutes. On these drugs—the drugs that matter most to patients—the government’s leverage to obtain discounts would be severely limited. In consequence, the companies’ motivation to develop them would remain largely, if not completely, unchanged. This motivation is likely

81. GAGNON & WOLFE, *supra* note 5, at 13 (“An accounting study based on the annual reports of 10 of the largest global pharmaceutical firms over the 10-year period from 1996 to 2005 revealed . . . a net return on shareholders’ invested capital of 29%.”); FUCHS & LEE, *supra* note 32 (“According to a January 2015 analysis by Aswath Damodaran, a professor at New York University Stern School of Business, the average yearly profit margin for the top 151 pharmaceutical companies world-wide is more than 24%.”); DONALD W. LIGHT & JOEL R. LEXCHIN, *Pharmaceutical Research and Development: What Do We Get for All That Money?*, 344 BRIT. MED. J. 4348, 4349 (2012) (“Net profits after taxes consistently remain substantially higher than profits for all other Fortune 500 companies.”); WHALEN, *supra* note 5 (“Pharmaceutical and biotechnology companies in the S&P 1500 earn an average net profit margin of 16%, compared with an average of about 7% for all companies in the index, according to S&P Capital IQ.”); *see also* EMANUEL, *supra* note 67.

Regardless of the risks, many drug companies are making huge profits. Gilead, maker of Sovaldi, has profits of around 50 percent. Biogen, Amgen and other biotech firms have profits of around 30 percent. Merck and Pfizer are seeing profits of 18 percent or more. Even if profits were cut by a third or a half, there would be sufficient incentive to assume the risks of drug development.

Id.; KANTARJIAN ET AL., *supra* note 12, at 210 (noting that “pharmaceutical companies were healthy and profitable a decade ago when cancer drug prices were on average less than \$30,000 per year”); *id.* at 208 (stating that in 2012, virtually every new cancer drug was priced above \$100,000 per year).

In contrast, an earlier study concluded that drug companies earned an average return on R&D of just 11.5%, only modestly above their cost of capital. *See* H. GRABOWSKI ET AL., *Returns on Research and Development for 1990s New Drug Innovations*, 30 PHARMACOECONOMICS 11, 27 (2002). The authors assert that their work supports a “virtuous rent seeking model,” in which increases in industry profitability lead to increases in R&D, which produce more new drugs and drive industry returns back to the competitive level. *Id.* at 28. The studies and sources cited above, however, suggest that this model is no longer working as fully as before, leaving industry profits at a high level for a significant period of time. To be sure, the model could reassert itself or the studies and sources could be wrong. To address this uncertainty, it would be important, as recommended below, to monitor the federal negotiation process and adjust payments to drug companies if significant problems with innovation develop. *See infra* notes 89–90 and accompanying text.

82. *See* COMANOR & SCHERER, *supra* note 37, at 108 (noting that “of drugs that survive all three [FDA] testing phases, only about one-third achieve sufficient commercial sales and profits to pay back the capitalized value of their R&D investments”); ROBERT A. INGRAM, *A Not-So-Transparent Attempt to Cap Drug Prices*, WALL ST. J., July 20, 2015, at A15 (“The U.S. Food and Drug Administration approves only 12% of potential medicines that enter clinical trials.”).

to be substantial, given the way these drugs are priced. Studies of new cancer drugs have found that drug makers base their prices not on the cost of developing them but on the price of the most similar existing treatment. Indeed, the new price is usually set above the price of the existing treatment, producing a steady escalation of new drug prices.⁸³ Because of the companies' pricing discretion, the incentive to generate "breakthrough" drugs would remain substantial, even if drug companies were forced to give rebates on all drugs.⁸⁴ In fact, because federal negotiation would increase the *relative* profitability of new, unique drugs, it may actually *heighten* the incentive to develop them.⁸⁵ Finally, the companies are aided in their search for the next breakthrough drug by the federal government's extensive support of basic scientific research.⁸⁶

In short, it appears that federal negotiation of Medicare prescription drug prices is unlikely to cause a large decline in new drug development, particularly of drugs that constitute a major therapeutic advance. At the same time, the prices of those important new drugs are likely to remain high and, so long as they are on patent, to increase significantly each year. Since the government has little power to reduce these prices through negotiation alone, it may be appropriate, if fiscal pressures

83. See Howard et al., *supra* note 12, at 154–55 (noting that oncologists, industry insiders, and others indicate that drug companies commonly use a reference price model—rather than costs—to set the prices of anticancer drugs; i.e., they price a new drug close to and often somewhat above the price of the most recent similar drug on the market, causing price levels to escalate over time); Andrew Pollack, *Drug Companies Increasingly Pushed to Explain High Prices*, N.Y. TIMES, July 23, 2015, at B1 (“In many cases, it appears, the price of new drugs is set in comparison to rival drugs already on the market, and usually a bit higher.”). In fact, drug companies have long used this model to set the launch prices of patented drugs that offer a therapeutic advance over existing medicines. See Lu & Comanor, *supra* note 37.

84. See CONG. BUDGET OFFICE, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS 55 (2011) (requiring drug companies to offer a minimum rebate “would not significantly reduce the incentive to develop ‘breakthrough’ drugs because those drugs could be launched at prices that were high enough to largely offset the rebate”); Brill, *supra* note 1 (“All the numbers tell one consistent story: Regulating drug prices the way other countries do would save tens of billions of dollars while still offering profit margins that would keep encouraging the pharmaceutical companies’ quest for the next great drug.”).

85. See Duggan & Morton, *supra* note 41, at 606 (suggesting that if “Part D reduces prices for drugs that have close substitutes rather than for drugs that do not have substitutes,” then it “increases the incentives for firms to invent novel treatments”).

86. See Kantarjian et al., *supra* note 12, at 209 (noting that “85% of cancer basic research is funded through taxpayers’ money; drug companies spend only 1.3% of their revenues on basic research”). Of course, the development, testing, and commercialization of a new drug requires much more than basic research. As a result, the bulk of new drug R&D is financed by the drug companies, not the federal government. For a calculation of the amounts involved, see Grabowski et al., *supra* note 81.

become acute, to turn to compulsory arbitration.

C. *Compulsory Arbitration*

Professors Frank and Newhouse have proposed a system in which the manufacturer, the government, and an independent expert would each name a price and the arbitrator would have to pick one.⁸⁷ The expert's price would aim to provide the manufacturer with a competitive return on its R&D, adjusted for risk and for the value of the drug.⁸⁸ Such a system could bring the prices of these major drugs closer to the optimal level, high enough to induce considerable future innovation but low enough to prevent excessive profit taking.

Compulsory arbitration deserves serious consideration, especially if the prices of new and unique drugs continue to soar. One virtue of the arbitration method just described is that it would produce three pricing proposals: one by the manufacturer, one by the government, and one by an independent expert. That diversity is likely to increase the chance that the arbitrator chooses the best price. For this reason, arbitration may well be superior to either direct regulation of new drug prices (in which the government alone sets the price) or the status quo (in which the manufacturer alone sets the price). On the other hand, it would be risky to adopt both federal negotiation and compulsory arbitration at the same time. That would reduce the prices of drugs with substitutes *and* the prices of unique drugs, which could cause pharmaceutical manufacturers to cut R&D precipitously. It may be more prudent as a first step to allow federal negotiation of Medicare drug prices without compulsory arbitration. If necessary, compulsory arbitration could be added later.

D. *Overall Assessment*

But whether or not arbitration is part of the package, federal negotiation of Medicare prescription drug prices ought to be pursued. As Section I.B showed, it is likely to produce substantial reductions in the prices of many drugs without creating large risks to innovation or consumer choice. Moreover, if problems do arise, they can be corrected. Medicare already sets the prices it pays hospitals, physicians, and long-term care facilities. To ensure that those payments are adequate to

87. See Frank & Newhouse, *supra* note 26, at 40–41.

88. See *id.* at 41 (stating that an expert's price would be "based on the expected break-even price for a drug, given the size of the market and the R&D costs in a therapeutic area, the incremental health benefit per unit of cost of the new drug, and the risk-adjusted rate of return").

generate the supply and quality desired, MEDPAC monitors them on a regular basis and recommends changes to Congress.⁸⁹ The same process should be applied to prescription drugs, providing a regular opportunity for adjustment.⁹⁰

Federal negotiation also enjoys widespread support. Polls show that most Americans, Republicans as well as Democrats, endorse it,⁹¹ and an increasing number of doctors are adding their voices.⁹² While new legislation may be improbable at the moment, congressional interest is likely to grow if rising federal healthcare expenditures threaten the nation's ability to fund fundamental national priorities.

In contrast, allowing large insurance companies to merge is unlikely to be a desirable way to lower healthcare costs. While large mergers are likely to increase buyer power—and sometimes reduce *both* excessive provider prices and premiums—most combinations of large insurance companies are likely to present significant competitive risks.

II. MERGERS OF INSURANCE COMPANIES

The U.S. healthcare system is a hybrid system, part public and part private. In the public programs, such as Medicare, Medicaid, and the

89. See generally MEDPAC, *supra* note 1. MEDPAC examines four issues: beneficiaries' access to care, quality of care, providers' access to capital, and current Medicare payments and providers' costs. If its analysis indicates that payments should be increased, it recommends payment updates to Congress. See *id.* at iii (stating that its report "fulfills the Commission's legislative mandate to evaluate Medicare payment issues and to make recommendations to the Congress"); *id.* at 41 (identifying the issues it considers).

90. Under this process, payments to providers would not be increased unless Congress passed legislation to increase them. See *id.* at iv (indicating that it is Congress' responsibility to "grapple with the difficult task of controlling the growth of Medicare spending while preserving beneficiaries' access to high-quality care and providing sufficient payment for efficient providers"). Therefore, if Congress did not act, a recommended increase in drug prices would not occur. But the risk of that seems small, since a price increase would have the support of the powerful drug lobby. See Whalen, *supra* note 5 (referring to "the drug industry's political clout").

91. See NAT'L COMM. TO PRES. SOC. SEC. & MEDICARE, ISSUE BRIEF – MEDICARE DRUG NEGOTIATION AND REBATES 2 (2014) ("National polls indicate that the majority of Americans, across party lines, support allowing Medicare to negotiate with drug companies to bring down the cost of prescription drugs.").

92. See Pollack, *supra* note 83 ("[M]ore than 100 prominent oncologists called for support of a grass-roots movement to stem the rapid increases of prices of cancer drugs, including by letting Medicare negotiate prices with pharmaceutical companies . . ."). In addition, both the leading Democratic presidential candidates and the *New York Times* support federal negotiation. See Margot Sanger-Katz, *Prescription Costs Arise as a Campaign Issue*, N.Y. TIMES, Sept. 22, 2015, at A3 (noting mounting public concern with prescription drug prices and proposals by Hillary Rodham Clinton and Bernie Sanders to address that concern); Editorial, *Use Medicare's Muscle to Lower Drug Prices*, N.Y. TIMES, Sept. 21, 2015, at A18; see also *supra* note 31 (providing sources indicating that President Obama concurs).

VA, the federal government is generally the purchaser of healthcare goods and services.⁹³ In the private segments, however, the principal source of buyer power is more fragmented: the numerous insurance companies, large and small, that cover individuals, small groups, and large employers. On behalf of their subscribers, these companies negotiate reimbursement rates with hospitals, physicians, pharmaceutical manufacturers, and other providers. Part II asks whether health insurers ought to be allowed to merge to exert greater buyer power against hospitals and physicians.

The answer depends on the resolution of three issues:

- (1) Is the merged firm likely to obtain lower prices from hospitals and physicians?
- (2) Are these lower prices likely to be procompetitive rather than anticompetitive (i.e., are they likely to reduce market power upstream rather than exploit small, competitive providers)?
- (3) Are these lower prices likely to be passed on to consumers (i.e., would the merger preserve competition downstream or would it instead create market power and raise insurance premiums)?⁹⁴

The following Sections address each issue, determining what it would take for a health insurance merger to be procompetitive on balance. The answer is not encouraging. A merger that is large enough to pass the first test (because it would lower provider prices significantly) may also fail the second and/or third tests (because it would exploit small providers and/or impose higher premiums on consumers). In consequence, it does not seem prudent, as a general rule, to promote mergers of large health insurance companies. Although some may be procompetitive—reducing both excessive provider prices and insurance premiums—most are likely to generate significant risks to competition.

A. *Lower Prices from Providers*

There is little doubt that a merger of substantial insurance companies would result in lower provider prices. Both economic theory and

93. The major exception is the procurement of prescription drugs for Medicare. As just discussed, that exception ought to be eliminated.

94. These three issues determine whether a health insurance merger is likely to enhance buyer power and whether that power is likely to benefit consumers, exploit powerless suppliers, or both. They are not the only issues that need to be addressed in evaluating the overall competitive impact of an insurance merger. It would also be necessary to consider, for example, whether the transaction would reduce operating costs or otherwise improve efficiency.

multiple studies indicate that insurance companies with greater bargaining power tend to obtain greater pricing concessions from providers. Thus, if the government were to allow two large insurance companies to merge, the reimbursement rates that hospitals and physicians receive would almost certainly fall.

The theoretical basis for this prediction is straightforward. It is the same theory that explains why private health plans are able to negotiate discounts from drug makers and why the federal government, if it were the sole buyer of prescription drugs for Medicare, would obtain even larger discounts. By merging, two health insurers would increase the volume of business they could move from one provider to another, enhancing their ability to reward providers that offer lower prices and penalize those that do not. Put another way, the value to a provider of being included in the insurer's network—or the loss from being excluded—would be greater.⁹⁵ As a result, the merged company could pit providers against each other more effectively.⁹⁶ In addition, it would be more difficult for a provider to resist the demands of the merged company when its market share has increased and the number of other insurers has fallen.⁹⁷

These theoretical observations have been repeatedly confirmed by empirical studies. After noting that “most previous studies find a negative relationship between insurer market share and prices,”⁹⁸ Moriya, Vogt, and Gaynor report the same conclusion: “[w]e find that increased insurance market concentration is significantly associated with lower hospital prices.”⁹⁹ Their results indicate that in a market with five

95. This is the reason health insurers use narrow networks to obtain larger discounts. See Reed Abelson, *Health Care Trade-Off: Fewer Choices, Lower Bills*, N.Y. TIMES, Apr. 14, 2015, at B2 (“Insurers say one way to lower the price of a plan is to limit the number of hospitals and doctors in their networks. They can then ask providers to discount their prices in return for a potentially higher volume of patients . . .”).

96. Many economists have recognized that health plans extract discounts from providers by playing them off against each other. See, e.g., Martin Gaynor & Robert J. Town, *Competition in Health Care Markets*, in 2 HANDBOOK OF HEALTH ECONOMICS 499, 504 (2012) (“The rise of HMOs during the 1990s is widely credited with significantly reducing health care cost growth, primarily through tough price negotiations.”); Katherine Ho, *Insurer-Provider Networks in the Medical Care Market*, 99 AM. ECON. REV. 393, 407 (2009) (quoting a hospital executive as saying “[t]here are examples where there were too many hospitals in an area and the plans played them off against each other to the point where the price paid was no more than marginal cost”).

97. Cf. MEDPAC, *supra* note 1, at 7 (“[I]nsurance market concentration can decrease health care spending because providers may have less leverage in negotiating prices where insurers are dominant . . .”).

98. Asako S. Moriya et al., *Hospital Prices and Market Structure in the Hospital and Insurance Industries*, 5 HEALTH ECON. POL'Y & L. 459, 461 (2010).

99. *Id.* at 476.

equally sized insurers, a merger of two of the companies would reduce hospital prices market wide by approximately 6.7%.¹⁰⁰ The authors remark that these findings are insufficient to show that health plans exercise monopsony power.¹⁰¹ That is correct. Given the concentration of hospital markets discussed below, it is likely that most hospitals possess market power. For this reason, when insurance companies bargain with them, the insurers ordinarily exercise countervailing power, not monopsony power.

Melnick, Shen, and Yu found similar results: “[h]igher health plan market concentration reduces hospital prices. . . . For example, a 1,000-point increase in the health plan concentration index is, on average, associated with 2.5 percent lower hospital prices.”¹⁰² They also found that “health plan concentration reduces hospital prices at a much greater rate in those areas where health plan markets are the most concentrated but reduces them at a much smaller rate in less concentrated ones.”¹⁰³ Both conclusions suggest that mergers of substantial health insurers are likely to benefit consumers, provided the mergers do not create market power downstream and raise insurance premiums. The authors state: “our results show that more concentrated health plan markets can counteract the price-increasing effects of concentrated hospital markets, and that—contrary to conventional wisdom—increased health plan concentration benefits consumers through lower hospital prices as long as health plan markets remain competitive.”¹⁰⁴

The most recent study endorses the same position.¹⁰⁵ Unlike the Moriya and Melnick studies, however, it also examines whether higher concentration among insurers tends to increase downstream market

100. *Id.* at 474–75. A somewhat larger increase in HHI (1000 points) “would reduce per-case prices by 8.4%.” *Id.* at 471. In a later review of the literature, Gaynor and Town caution that these “results are very sensitive to the inclusion of one or two states.” Gaynor & Town, *supra* note 96, at 625.

101. Moriya et al., *supra* note 98, at 476.

102. Glenn A. Melnick et al., *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFF. 1728, 1730 (2011).

103. *Id.*

104. *Id.* at 1728.

105. See Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104, 113 (2015).

[O]ur findings . . . suggest that higher levels of insurer bargaining leverage with hospitals may lead to lower health insurance premiums via lower negotiated hospital prices, as long as there is sufficient competition in the market for selling insurance to small employers that these lower prices get passed through to employers in the form of lower premiums.

Id.

power and finds that it does, potentially offsetting any benefits from greater buyer power.¹⁰⁶ The study's distinctive contribution, however, is that it uncovers evidence that the impact of buyer power *exceeds* the impact of higher downstream concentration and that a merger of insurance companies may therefore increase consumer welfare. Section II.C discusses this provocative finding in more detail. As that discussion explains, the net impact on consumers is small. Moreover, the study does not address another potentially fatal objection to a merger of insurers—that it would enable the merged firm to exercise monopsony power against small providers.

Section II.B examines that issue, looking at how often a merged insurer is likely to exercise monopsony power, rather than countervailing power. Section II.B also addresses the likely consequences of monopsony power for consumers as well as small providers.

B. Effects of Lower Provider Prices

1. Countervailing Power

As the prior discussion suggests, a merger of insurance companies is more likely to be procompetitive where the merged company would exercise *countervailing power* against providers, forcing hospitals and physician groups with market power to lower their prices closer to the competitive level. Those lower prices would enable the merged firm to reduce premiums and co-pays, enhancing competition in the insurance market and benefiting consumers. In contrast, a merger would have anticompetitive effects if the merged firm would exercise *monopsony power* against small providers, forcing them to accept prices *below* the competitive level. In that situation, as explained below, the reduction in provider prices is unlikely to enhance competition downstream or benefit consumers, but it would exploit vulnerable providers. In short, the desirability of lower provider prices hinges in large part on whether they reflect the exercise of countervailing power against providers with market power or monopsony power against small, powerless providers. As the next two Sections describe, the evidence indicates that most hospitals and some physician groups possess market power. Other physician groups, however, are likely to be vulnerable to the exercise of monopsony power.

106. See *id.* at 109 (finding a statistically significant, positive relationship between insurer concentration and premiums paid by small employers, holding all other factors constant, including the impact of insurer concentration on hospital prices).

a. *Hospitals*

Hospitals, the largest providers in the American healthcare system, frequently exercise market power. That power flows from several sources. First, most hospital markets are concentrated. A recent study by Cutler and Morton found that “concentration is pervasive. Nearly half (n=150) of hospital markets in the United States are highly concentrated, another third (n=98) are moderately concentrated, and the remaining one-sixth (n=58) are unconcentrated. No hospital markets are considered highly competitive.”¹⁰⁷ Other studies have reached the same conclusion.¹⁰⁸ In addition, mergers contribute to these high levels of concentration and many retrospective studies have found that hospital mergers led to higher prices. For example, a “recent summary cites 8 studies that show price increases in the range of 10% to 40% due to mergers.”¹⁰⁹

Market power can also result from the distinctive prestige that certain hospitals possess. As Cutler and Morton note:

flagship academic medical centers offering perceived higher quality care often wield enormous market power. . . . [C]onsumers highly value the option of obtaining care at these hospitals, and . . . a patient who has a serious illness and also is well insured will seek out these hospitals with little regard for price.¹¹⁰

107. David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1966 (2013). The authors used the concentration thresholds in the federal government’s merger guidelines. *See id.* at 1965, 1970.

108. *See* Cotter, *supra* note 38, at 5 (“According to Capps and Dranove, the average metropolitan statistical area HHI in the market for hospital ownership as of 2009 was ‘roughly 4700,’ well above the level (2500) the enforcement agencies consider highly concentrated.” (citing CORY CAPPS & DAVID DRANOVE, BATES WHITE, MARKET CONCENTRATION OF HOSPITALS 2 (2011), <http://www.ahipcoverage.com/wp-content/uploads/2011/06/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf> [<https://perma.cc/J4X5-JB2S>]); Gaynor & Town, *supra* note 96, at 503 (“[H]ospital markets are highly concentrated on average”); *id.* (“In 2006, of the 332 MSAs in the US, 250 had HHIs greater than 2,500.”).

109. Cutler & Morton, *supra* note 107, at 1967–68 (citing *Health Care Industry Consolidation: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 112th Cong. (2011) (statement of Martin Gaynor, Professor, H. John Heinz III School of Public Policy & Management, Carnegie Mellon University)); *see also* Gaynor & Town, *supra* note 96, at 551–52 (concluding, after reviewing the literature, that “on average, hospital mergers result in increases in price”); Moriya et al., *supra* note 98, at 461 (“There are a large number of studies assessing hospital market power. . . . The vast majority of these studies find that concentration increases hospital prices.”).

110. Cutler & Morton, *supra* note 107, at 1967; *see also* Ho, *supra* note 96, at 407–08 (quoting a hospital director stating that “the prices [the best hospitals] charge are based on their very high patient satisfaction results and their strong reputation. They can get high prices from any plan in the market”).

A large metropolitan hospital may also command a price premium because it specializes in advanced procedures and has performed them in sufficient volume that no other hospital in the area can match its quality.¹¹¹ Finally, market power can arise from membership in a healthcare system. Even if no hospitals in the system are direct competitors, the system may possess considerable market power because it contains so many hospitals in a region that health plans cannot be widely marketed in that region without including the system in their networks.¹¹²

Most hospitals, in short, have market power, whether they operate in concentrated markets, enjoy distinctive prestige, or belong to a large system. Confronting a hospital with market power, a health plan can negotiate larger discounts if it acquires a competing plan and increases the countervailing power it can exercise against that hospital.¹¹³

b. Physicians

Physicians typically negotiate with health insurance companies by collaborating in some way. They may form a group practice such as a large, multi-specialty clinic or a smaller unit made up entirely of doctors practicing a single specialty. They may join a major healthcare system made up of multiple hospitals, physicians, nurses, and other professionals. Or they may band together into an independent practice association (IPA) that negotiates contracts with particular health plans and shares the risks of those contracts, but otherwise preserves the independence of its members.¹¹⁴ Whatever form the doctors choose,

111. See Cutler & Morton, *supra* note 107, at 1966 (“The learning curve for individual physicians and surgical teams means that the large hospital in a city or region will frequently offer better care options to patients.”).

112. See EMANUEL, *supra* note 2, at 75.

Within the last few years larger hospitals have been buying up neighboring hospitals to form large hospital systems. A primary rationale is to increase the hospitals’ bargaining power with the commercial insurers in order to be able to raise their rates. If many of the hospitals in a geographic region are part of a single hospital system, then the insurer must include them in a network and the hospital system can demand higher rates.

Id.

113. While countervailing power is generally procompetitive, it can also be exercised in anticompetitive ways. In an earlier article, I identified and discussed ten anticompetitive scenarios. See Kirkwood, *supra* note 19, at 1536–58. Although they are outside the scope of this Article, any comprehensive analysis of a large insurance merger would have to consider those possibilities as well.

114. See Abe Dunn & Adam Hale Shapiro, *Do Physicians Possess Market Power?*, 57 J.L. & ECON. 159, 163 n.8 (2014). In the Seattle area, for example, as their websites indicate, the Polyclinic is a multi-specialty clinic, Northwest Asthma & Allergy is a more narrowly specialized clinic, UW Medicine is a major healthcare system (with four hospitals, more than 1800 physicians

these collaborations, if large or distinctive enough, may create market power.

There is little systematic evidence on the extent of physician market power,¹¹⁵ but there is good reason to believe it exists. In 2013, a national commission on physician payment reform observed that “physicians are banding together in larger groups to increase their own bargaining power and gain higher reimbursement.”¹¹⁶ In 2014, an econometric study found statistically significant evidence that doctors in more concentrated markets charge higher prices than doctors in more competitive markets.¹¹⁷ The difference was substantial: “a physician in a market with the 90th-percentile concentration will charge fees that are approximately 14-30 percent higher than a physician in the 10th-percentile market.”¹¹⁸ The authors also found that consolidation of physicians “has a much stronger effect on prices when the market is initially more concentrated.”¹¹⁹ In an unconcentrated market, a merger of two physicians groups would have an imperceptible impact on prices. But in a market with three equal-sized groups, a merger of two of them would increase prices ten percent to fourteen percent.¹²⁰ Thus, the authors conclude: “physicians in concentrated markets are able to exercise market power.”¹²¹

The study also found evidence that physicians, like hospitals, charge lower prices when insurance markets are more concentrated.¹²² But the desirability of these lower prices is less clear. Had all the physicians been exercising market power, the reductions would have been

and other professionals, and twelve neighborhood clinics), and Northwest Physicians Network is an independent practice association.

115. *See id.* at 160 (“[T]here has been very little research regarding physicians’ bargaining power.”); Gaynor & Town, *supra* note 96, at 611 (“[T]he empirical literature on physician competition is quite sparse.”).

116. REPORT OF THE NATIONAL COMMISSION ON PHYSICIAN PAYMENT REFORM 8 (2013).

117. *See* Dunn & Shapiro, *supra* note 114, at 162 (“We find that physician concentration is positively and significantly correlated with service price levels.”).

118. *Id.* In one of the specialties studied, cardiology, the ninetieth concentration percentile was 4080 while the tenth percentile was 110. *See id.* at 174 (referring to the HHI figures as .408 and .011). The authors did not provide comparable figures for the other specialty, orthopedics. They also used a complicated method to estimate physician concentration, since they did not have revenue data for individual physician groups.

119. *Id.* at 182.

120. *Id.*

121. *Id.* at 186. Just as with hospitals, when there are fewer physician groups in a market, health insurers find it more difficult to induce discounts by threatening to move business elsewhere. There are fewer options available.

122. *Id.*

beneficial. As Professor Gaynor has observed: “[i]nsurers can engage in hard bargaining with physicians that can make subscribers better off through reduced premiums.”¹²³ But if some of the doctors had been pricing competitively, and the insurers obtained lower prices by exercising monopsony power against them, the reduced prices would be less desirable, as the following Section explains. It first looks at whether health insurers are likely to exert monopsony power over hospitals and then turns to physicians.

2. Monopsony Power

a. Hospitals

The literature contains few, if any, examples of a monopsonistic health insurer exploiting a powerless hospital. There is one recent allegation: in *West Penn Allegheny Health System, Inc. v. UPMC*,¹²⁴ the plaintiff claimed that Highmark, the dominant health insurer in the Pittsburgh area with a market share of sixty percent to eighty percent,¹²⁵ exercised monopsony power against the plaintiff, a relatively small hospital with a market share of twenty-three percent.¹²⁶ As a result, the plaintiff alleged that Highmark forced it to accept reimbursement rates that were below the competitive level.¹²⁷ While the Third Circuit refused to dismiss these charges, it did not discuss whether there was evidence to support them. This is symptomatic. There is little evidence that health plans exercise monopsony power over hospitals, even small hospitals with low market shares. Although there is, as noted above, extensive evidence that insurers in more concentrated insurance markets obtain lower prices from hospitals, these lower prices are more likely to represent the exercise of countervailing power, since hospital markets are typically concentrated and most hospitals in them appear to have market power.¹²⁸

It is possible, of course, that a dominant insurance company might exercise monopsony power against a small hospital in a concentrated

123. Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 506 (2006).

124. 627 F.3d 85 (3d Cir. 2010).

125. *Id.* at 92. According to the complaint, the only other significant insurer was UPMC Health Plan and it was basically unwilling to deal with the plaintiff. *See id.* at 104 n.12.

126. *Id.* at 91; *see also id.* at 103 (“[T]he complaint suggests that Highmark has substantial monopsony power.”).

127. *See id.* at 103.

128. *See supra* Section II.B.1.a.

market that was not charging supracompetitive prices. If so, a merger that would create such a dominant insurance company might well warrant an antitrust challenge, even if the merger would also enable the company to exercise procompetitive countervailing power against hospitals with market power. The next Section discusses that issue—whether a merger that would produce both monopsony power and procompetitive countervailing power should be illegal—in the context where it is more likely to arise: physician markets.

b. Physicians

If doctors negotiated their reimbursement rates with large insurance companies on an individual basis, there would be considerable reason to fear the exercise of monopsony power. Most individual doctors do not possess significant market power. But, as mentioned earlier, physicians ordinarily collaborate—in group practices, health systems, or IPAs—when they negotiate with insurers, and in concentrated physician markets, there is evidence that these associations exercise market power.¹²⁹ In unconcentrated markets, though, these groups are unlikely to have market power and, even in concentrated markets, some of them are likely to be essentially powerless. In consequence, a merger of insurance companies may well create monopsony power over at least some physician practices. The clearest case would involve a merger that creates a dominant health plan in a local market where the physicians are organized into numerous small groups, none of which has market power.

In that situation, there is reason to expect multiple adverse effects. First, the exertion of monopsony power would harm the physicians, reducing their fees below the competitive level and transferring some of their wealth to the merged insurance company. Such a coerced transfer of wealth is a type of theft and is one of the prime reasons why Congress passed the antitrust laws. While Congress's principal goal was to protect consumers, Congress also wanted to protect atomistic suppliers such as farmers and small businesses from monopsony power gained through anticompetitive means.¹³⁰ In short, Congress intended to stop unjustified

129. See *supra* notes 116–21 and accompanying text.

130. See John B. Kirkwood, *The Essence of Antitrust: Protecting Consumers and Small Suppliers from Anticompetitive Conduct*, 81 *FORDHAM L. REV.* 2425, 2434–35, 2442 (2013); John B. Kirkwood & Robert H. Lande, *The Fundamental Goal of Antitrust: Protecting Consumers, Not Increasing Efficiency*, 84 *NOTRE DAME L. REV.* 191, 207–09, 233–36 (2008); Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 *ANTITRUST L.J.* 707, 714 (2007).

transfers of wealth on both the buy side and the sell side.¹³¹

In addition, reducing doctors' reimbursement is likely to harm consumers. Paid less for the work they do, the doctors in the relevant market may work fewer hours or devote less time to each patient,¹³² and fewer doctors are likely to enter the market. To be sure, the impact may not be large. There are numerous reasons—personal, professional, and legal—why a doctor would want to give each patient all the care he or she needs.¹³³ But as experience with Medicaid has indicated, significantly lower reimbursement rates do cause some doctors to refuse to take new patients and to spend less time with existing patients.¹³⁴ Of course, not every reduction in the quantity of healthcare services provided is undesirable. Services may be excessive because providers have market power and their supracompetitive margins entice them to provide additional services.¹³⁵ Similarly, services may be excessive because of the perverse incentives of the fee-for-service payment system.¹³⁶ But both effects are less likely in a competitive market and should become less likely in the future as payers move away from payments based on services to payments based on outcomes.¹³⁷ In short,

131. For a particularly telling example of this dual objective, see 21 CONG. REC. 4098 (1890) (statement of Rep. Taylor) (“This monster [the beef trust] robs the farmer on the one hand and the consumer on the other.”). For other statements by members of Congress that equate unjustified wealth transfers with robbery or extortion, see Kirkwood, *supra* note 130, at 2434–35.

132. See Roger D. Blair & Jill Boylston Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis*, 71 ANTITRUST L.J. 989, 1014–15 (2004).

Some physicians may try to make up the lower reimbursement on volume, i.e., by seeing more patients per hour. This, of course, means spending less time with each patient. Even if the physician can still diagnose ailments correctly, the hurried environment may leave patients less satisfied. Worse, of course, is the distinct possibility that something important will be missed.

Id.; Gaynor, *supra* note 123, at 506 (“If insurers possess monopsony power . . . they may push reimbursements so low that physicians supply less than the socially optimal quantity or quality of services.”). In addition, as David Frankford has pointed out to me, physicians may compensate for lower reimbursement rates by substituting more intensive services for less intensive ones. That could harm consumers if the more intensive services result in greater total costs or produce more frequent side effects.

133. See Jill Boylston Herndon, *Health Insurer Monopsony Power: The All-or-None Model*, 21 J. HEALTH ECON. 197, 202–03 (2002).

134. See Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1721 (2010) (“[I]n today's Medicaid program . . . rates to providers are typically well below both commercial and Medicare rates. As a result, many physicians do not accept Medicaid patients, and . . . Medicaid enrollees often are treated less intensively for a given condition.”).

135. For example, if margins are high on certain tests, a physician may be tempted to order the tests more frequently.

136. See Blair & Herndon, *supra* note 132, at 998 n.31 (referring to the “overutilization of services that typifies fee-for-service medicine”).

137. See, e.g., Sylvia M. Burwell, *Setting Value-Based Payment Goals—HHS Efforts to Improve*

if a merger confers monopsony power, it is likely to depress the supply of desirable services.

This adverse consequence is unlikely to be outweighed by lower prices to consumers. In the textbook monopsony model, consumers do not benefit from the lower input prices obtained by a monopsonist. Instead, the monopsonist achieves those prices by *reducing* the volume of purchases below the competitive level. That tends to reduce the quantity of output the monopsonist offers for sale, which tends to raise prices to consumers, not lower them.¹³⁸ In the monopsony model, in short, there is *no* pass through of lower input prices to consumers.¹³⁹ In healthcare markets, however, the prices that consumers with insurance pay are determined by negotiations between the consumer's insurer and providers, not by the quantity of output that either providers or insurance companies offer to sell. As a result, if a monopsonist insurer forces small physician groups to accept lower reimbursement rates, those rates could be passed on to the insurer's subscribers in lower co-pays and lower premiums. This benefit to consumers is limited, however, by the intensity of downstream competition among insurance companies. Where downstream competition is intense, a monopsonist might well pass on lower provider prices in order to gain market share. But where the merger that created monopsony power would also create downstream market power—a likely combination, as the next section explains—the merged firm's profit maximizing strategy may well be to raise premiums, not lower them. In *West Penn*, for example, the plaintiff alleged that Highmark, the dominant health insurer in the Pittsburgh area, did not pass on the lower reimbursement rates it extracted from the plaintiff but instead “repeatedly ratchet[ed] up insurance premiums.”¹⁴⁰

U.S. Health Care, 372 NEW ENG. J. MED. 897, 897 (2015).

A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018.

Id.

138. Suppose, for example, that a firm acquires monopsony power over timber owners by acquiring all the sawmills in an area. The firm would exercise that power by reducing its purchases of timber. That, in turn, would reduce the amount of cut lumber the monopsonist would offer for sale, which would tend to raise the price of lumber for customers.

139. See Roger G. Noll, “Buyer Power” and Economic Policy, 72 ANTITRUST L.J. 589, 606 (2005); Kirkwood, *supra* note 19, at 1498; Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 CORNELL L. REV. 297, 339 (1991).

140. *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 104 (3d Cir. 2010). Likewise, the Department of Justice recently challenged a merger of two Michigan health insurers, alleging it would create a firm with approximately ninety percent of the Lansing market. As a result, it would

In sum, if the physician market is unconcentrated, as it appears to be in many urban areas,¹⁴¹ a merger that created an insurance company with monopsony power would not only harm the physicians, it would probably harm consumers as well, both by reducing the supply of physician services and by raising insurance premiums.

But suppose the physician market was composed of several large groups with market power *and* a few small groups with little or no power. Then a merger of insurance companies could raise overall consumer welfare, since the positive effects of the merged firm's countervailing power might outweigh the negative effects of its monopsony power. But even if that were true, the merger should probably be blocked. As emphasized earlier, one of the fundamental goals of the antitrust laws is to protect small, powerless suppliers from the exercise of monopsony power.¹⁴² While Congress cared at least as much about consumers, there was little or no support for allowing mergers that created countervailing power, even though they would generally benefit consumers. Thus, if a merger was likely to produce both monopsony power and countervailing power, my judgment is that Congress, had it addressed the issue, would have assigned higher weight to protecting small suppliers from exploitation. The Horizontal Merger Guidelines address an analogous situation—a merger of sellers that would allow the merged firm to exercise market power over a subset of its customers—and indicate that such a merger may be challenged, even if it benefits consumers overall.¹⁴³ The Guidelines therefore reach a similar conclusion: where a merger would produce both anticompetitive harm to one group of suppliers or customers and procompetitive benefit to another group, the harm may be sufficient, by itself, to warrant an antitrust challenge.¹⁴⁴

not only lower reimbursement rates for doctors but raise premiums for employers. See DAVID BALTO, CTR. FOR AM. PROGRESS, MAKING HEALTH REFORM WORK: ACCOUNTABLE CARE ORGANIZATIONS AND COMPETITION 10 (2011), http://www.americanprogress.org/issues/2011/02/aco_competition.html [<https://perma.cc/2WNU-R22B>].

141. See Dunn & Shapiro, *supra* note 114, at 174 n.31.

142. See *supra* note 130 and accompanying text.

143. See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 4.1.4 (2010), <http://www.ftc.gov/os/2010/08/100819hmg.pdf> [<https://perma.cc/5WA7-T89M>] (discussing a merger that would allow the merged firm to price discriminate against a targeted subset of its customers and stating that “the Agencies may identify relevant markets defined around those targeted customers”).

144. To be sure, the government could exercise its prosecutorial discretion and allow the merger if the amount of monopsony power created was minimal relative to the amount of procompetitive countervailing power. But if the monopsony power was significant, the government need not engage in such balancing.

Of course, the ultimate impact of an insurance merger on consumers would depend not only on the type of buyer power it would create, but whether it would also create downstream market power. Section II.C addresses this critical issue.

C. *Downstream Market Power*

If a merger of health insurers is large enough to create significant buyer power, it may produce downstream market power as well, enabling the merged firm to raise premiums or reduce product quality.¹⁴⁵ If the insurance markets in a geographic area are concentrated on the buying side, they are likely to be concentrated on the selling side as well. After all, it is the same companies operating on both sides of the market. Thus, one major hurdle for two insurance companies attempting to merge would be to show that their combination would create countervailing power upstream but not an equivalent degree of market power downstream, producing a net gain for consumers.

There are two principal ways of accomplishing this. One way is to show that insurance markets are relatively unconcentrated and that the merged firm would be able to exercise countervailing power but not market power. That is possible because, as numerous scholars have concluded, countervailing power can be exerted at relatively modest market shares—shares below what would normally be necessary to exercise single-firm market power.¹⁴⁶ Thus, in a relatively

145. Indeed, a merger that creates downstream market power could result in both higher premiums and reduced product quality. If a purchaser (a “plan sponsor”) balks at paying the higher premiums, the insurance company may insist that it accept a less comprehensive health plan instead. See SARA ROSENBAUM & DAVID M. FRANKFORD, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 252 (2d ed. 2012–15 Update) (“[I]f plan sponsors resist higher premiums, they then have to accept plans with higher out-of-pocket costs for plan members, more shallow coverage, narrower networks, or some combination of the above—all forms of less comprehensive insurance.”).

146. See, e.g., Misha Petrovic & Gary G. Hamilton, *Making Global Markets: Wal-Mart and Its Suppliers*, in *WAL-MART: THE FACE OF TWENTY-FIRST CENTURY CAPITALISM* 131 (Nelson Lichtenstein ed., 2006) (“Even for the biggest manufacturers of packaged consumer goods, from Procter and Gamble to Clorox and Revlon and from Del Monte to Nabisco and Sara Lee, the amount of business with Wal-Mart—typically ranging between 15 percent and 30 percent of total shipments—creates a significant dependency on the retailer’s demands.”); Paul W. Dobson & Roman Inderst, *The Waterbed Effect: Where Buying and Selling Power Come Together*, 2008 *WIS. L. REV.* 331, 356 (“[A] buyer (or a group of buyers) could wield substantial buyer power . . . at levels of size and market share considerably below those that are needed to establish seller power in the final market.”); Benjamin Klein & Kevin M. Murphy, *Exclusive Dealing Intensifies Competition for Distribution*, 75 *ANTITRUST L.J.* 433, 449 (2008) (“[S]ignificantly lower wholesale prices can be achieved by retailers with relatively small market shares as long as the retailer has the ability to influence the share of its customers’ purchases . . . obtained by a chosen manufacturer.”); see also Kirkwood, *supra* note 19, at 1503–04 (citing additional support).

unconcentrated insurance market, a merger that resulted in an insurer with a twenty-five percent share may well enable the insurer to exercise countervailing power but not market power. If so, the merged firm is likely to be able to obtain lower prices from providers and, since the downstream market would remain competitive, it is likely to pass on those lower prices to consumers in the form of lower co-pays and premiums. Fuchs and Lee offer an example. They point out that in some local markets in California, “consumers will have a choice of seven different insurers.”¹⁴⁷ At the same time, they contend that many hospitals and specialty physician practices exert market power.¹⁴⁸ Where that is the case—where the downstream market is fragmented and upstream provider markets are concentrated—a merger of substantial health plans might create a firm that could exercise greater procompetitive countervailing power but *neither* monopsony power *nor* downstream market power.

The second way to demonstrate consumer benefit would be to show that even though the merged firm would acquire both countervailing power and downstream market power, the effect of the former would outweigh the latter. This could happen if the merged firm obtains such substantial discounts from providers that its optimal strategy, despite the gain in market power, would be to *lower* premiums. In theory this is plausible, since even a merger to monopoly would result in a lower price if marginal costs fall enough. As Trish and Herring note, “a reduction in negotiated provider prices is essentially a downward shift in the insurer’s marginal cost curve.”¹⁴⁹

In their recent study, Trish and Herring found evidence of the second mechanism of consumer benefit but not the first. They did not find evidence that mergers of insurance companies were likely to create buyer power without creating seller power. Rather, they found that higher insurer concentration was associated with both greater buyer power and greater market power.¹⁵⁰ They did, however, uncover evidence that the effect of buyer power is likely to outweigh—though not by much—the effect of greater seller power, leading to a small reduction in premiums. Their regressions implied that in a market of five equal-sized insurance companies,¹⁵¹ a merger of two of them would

147. Fuchs & Lee, *supra* note 32.

148. *See id.*

149. Trish & Herring, *supra* note 105, at 107.

150. *See id.* at 105, 109.

151. The HHI in such a market would be 2000.

lower premiums by twelve dollars—less than 0.3%.¹⁵² This reduction is tiny and does not constitute a strong argument for allowing mergers where the result would be both greater market power and greater buyer power.

Moreover, unlike Trish and Herring, most researchers find that in more concentrated insurance markets, prices are higher, not lower. While they do not generally attempt to measure the impact of buyer power, their results suggest that, whatever its impact, it was not enough to offset the price-raising effect of greater downstream market power. Professor Dafny summarizes the current state of the literature:

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market (self- and fully-insured combined), and Medicare Advantage. . . .

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums.¹⁵³

In short, if a merger of large insurance companies were to increase concentration substantially in a downstream market, the bulk of the evidence indicates that premiums would go up, even though the merger is also likely to enable the merged firm to force providers with market power to charge lower prices. Dafny concluded: “[i]f past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.”¹⁵⁴

152. The authors used different measures of concentration to disentangle the effects of greater concentration on buyer power and market power. Specifically, they measured buy-side concentration across the entire array of an insurer’s business, including its fully insured products and its administrative services (such as claims processing and organizing provider networks), which are typically sold to large employers that self-insure. They measured sell-side concentration in the sale of fully insured products only. See Trish & Herring, *supra* note 105, at 105. The first measure indicated that a five-to-four merger would lower premiums by 1.9% (\$90). The second measure indicated that such a merger would raise premiums by 1.7% (\$78). The combined effect of both measures—the increase in buyer power and the increase in market power—would be a reduction in premiums of \$12. See *id.* at 109.

153. *Health Insurance Industry Consolidation: What Do We Know from the Past, Is It Relevant in Light of the ACA, and What Should We Ask?: Hearing Before the Subcomm. on Antitrust, Competition Pol’y, and Consumer Rights of the S. Comm. on the Judiciary*, 114th Cong. 11 (2015) (statement of Leemore S. Dafny, Professor, Kellogg School of Management, Northwestern University) [hereinafter *Health Insurance Industry Consolidation*]; see also Gaynor & Town, *supra* note 96, at 609 (“Most of the studies find evidence that competition leads to lower prices.”).

154. *Health Insurance Industry Consolidation*, *supra* note 153, at 9.

To be sure, the likelihood of an adverse downstream effect may be reduced by the Affordable Care Act. Its Medical Loss Ratio (MLR) provisions mandate that insurers “spend at least 80%–85% of every premium dollar on consumer medical claims and activities that improve the quality of care.”¹⁵⁵ Where this requirement is binding—where the insurer’s MLR is at or below the required floor—the insurer could not raise premiums to take advantage of the greater downstream market power it gained through a merger.

The MLR requirements, however, are no panacea. They are a limited and sometimes perverse form of price regulation that may not help and sometimes may hurt consumers. The requirements are limited in three ways. First, they apply only to fully insured health plans.¹⁵⁶ That creates a large lacuna since “more than half of privately-insured enrollees are in self-insured plans.”¹⁵⁷ Second, the MLR requirements are floors, not ceilings, and thus do not prevent an insurer from raising premiums where it already exceeds the minima. A recent study by the Commonwealth Fund found that, on average, MLRs across the nation were *above* the floors.¹⁵⁸ Third, the requirements, even where they are binding, do not preclude an insurer from restricting non-price competition. An insurer could reduce the size or prestige of its provider network or limit its spending on customer service while maintaining its MLRs.¹⁵⁹

The MLR provisions also create perverse incentives. When an MLR floor is binding, it becomes less profitable to invest in steps that reduce the costs of medical services. Suppose an insurer is considering developing a new payment system that would improve quality of care while lowering payments to providers. If the system is successful, it would reduce the insurer’s claims expenses, but that would diminish its MLR and force it to lower premiums, curtailing the return it could earn

155. Fuchs & Lee, *supra* note 32. These provisions apply to fully insured health plans and require that large group plans spend at least eighty-five percent of net premiums on medical services and quality improvement. For small group and individual plans, the minimum MLR is eighty percent. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010).

156. See *Health Insurance Industry Consolidation*, *supra* note 153, at 14; Patient Protection and Affordable Care Act § 10101(f).

157. *Health Insurance Industry Consolidation*, *supra* note 153, at 14.

158. *Id.* (“[T]he non-profit Commonwealth Fund reports the following national MLRs for 2013: 85.9% (individual); 83.6% (small group); 88.6% (large group).”).

159. In other words, if an insurance company gained market power through a merger, but, because of the MLR requirements, could not raise premiums, the company could still take advantage of that power by spending less on efforts to improve quality.

on developing the new payment system. Similarly, if a merger enabled an insurance company to exert greater desirable buyer power (procompetitive countervailing power), the MLR requirements, if binding, would make it less profitable to exert that power, since lower provider payments would reduce the company's MLR and diminish its profits.

Thus, while the MLR provisions may limit the exercise of downstream market power, they would not apply in many instances and, when they do apply, would create a disincentive to curb payments to providers. Despite the MLR requirements, in short, many large insurance mergers may still pose a significant threat to competition and consumers.

D. Overall Assessment

Some mergers of insurance companies may increase competition by enhancing buyer power. They may enable the merged firm to exert procompetitive countervailing power, lower excessive provider prices, and then pass on those lower prices to consumers in the form of lower co-pays and premiums. But a merger that is large enough to create significant buyer power could also create monopsony power, anticompetitive countervailing power, or downstream market power. Moreover, there appears to be no systematic evidence that all three forms of power are rare. To the contrary, none of the economic studies cited in this Article found that insurance mergers are likely to create procompetitive countervailing power without also creating offsetting or nearly offsetting downstream market power. As a result, it does not appear that mergers of large insurance companies are a generally attractive method of utilizing buyer power to control healthcare costs.¹⁶⁰

CONCLUSION

One of the major reasons why healthcare costs are higher in America

160. Some have raised yet another reason to prohibit large insurance company mergers: if insurers combine, providers will want to combine in response, potentially leading to a cascade of mergers and counter-mergers. But if a merger of health insurers was procompetitive, there would be no reason to allow providers to merge in response. Because a procompetitive health insurance merger would not create monopsony power or anticompetitive countervailing power, there would be no basis to resist the buyer power it would create. To be sure, a merger that produced procompetitive countervailing power might result in monopsony power in the future if some provider market were to deconcentrate, but that is unlikely. Providers today feel pressures to consolidate, not separate. *See, e.g.,* Anna Wilde Mathews, *Health Law Speeds Merger Frenzy*, WALL ST. J., Sept. 22, 2015, at B1 ("Five years after the Affordable Care Act helped set off a health-care merger frenzy, the pace of consolidation is accelerating.").

than in other countries is that our prices are exceptionally high. This Article addresses whether we ought to rely more heavily on buyer power to reduce those prices, as other nations do. It concludes that the country's most powerful buyer, the federal government, should be allowed to negotiate the prices of prescription drugs used by Medicare. Unleashing the federal government's buyer power is likely to reduce drug prices substantially without causing major adverse effects on new drug development or the array of medicines available to beneficiaries. In contrast, it would not be advantageous to encourage large insurance companies to merge to exert greater buyer power against hospitals or physicians. While some insurance mergers may be beneficial—and lower both excessive provider prices and premiums—most large mergers are likely to present significant competitive issues: they may well create one or more types of power (monopsony power, anticompetitive countervailing power, or downstream market power) that would render them anticompetitive on balance.

In short, it appears more desirable to utilize the buyer power of the federal government than to magnify the buyer power of major health plans. That is so, in essence, because a profit maximizing health plan would exploit whatever anticompetitive power it gains through merger, harming small physician groups, for example, or forcing consumers to pay higher premiums. In contrast, whatever its drawbacks as a regulator, the federal government has no inherent incentive to exploit either small providers or consumers. This point, in combination with the government's commanding buyer power, supplies another reason to consider moving the entire healthcare system to a single payer.

