

# Healthcare and Antitrust in the United States

Fiona Scott Morton  
Yale School of Management

Baker Institute  
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# Antitrust in healthcare

Topical and interesting

1. Pharmaceuticals – pay for delay
2. Competition among insurers – MFNs
3. Hospital mergers – market definition
4. Antitrust scrutiny of ACOs



# Pharmaceuticals: pay for delay

## Suppose

Brand has patent due to run for 10 years

Brand will earn \$500m for the remainder of patent life

Generic challenges the patent under Hatch-Waxman

Generic expects to earn \$10m in total profit from entry

Recall, the first generic to succeed gets 6 months of exclusivity.

That right blocks subsequent entry until it's used.

Further suppose the patent has only a 50% chance of surviving.

A loss destroys all brand profits; a win keeps the status quo.

Solution: settle with generic not to enter for  $10 < \$x < 250$

The brand will face no competition!



# FTC argument

Brand is engaging in illegal monopolization by paying the entrant to stay out of its market

=> Violation of the FTC Act s5

(and logically the Sherman Act s2 also)

The consumer is deprived of generic prices until patent exp  
FTC argues that settlements that use the time of entry to divide profits are presumptively good for consumers

- to see this, note the negotiated time reflects the strength of the patent
- outcome is in expectation, what generic would get in litigation without needing to litigate
- Prices fall and benefit consumers



# Change in patents

Classic vision of a patent is:

- one patent, one product, valid

- e.g. a patent on a new molecule that cures something

Unfortunately, PTO grants all sorts of patents that are vague, weak, and very likely to be invalid

- patent on a green oval pill scored a certain way

- patent on an alternative isomer, salt, or inert ingredient

- patent on the extended release version

Scott Hemphill has shown that empirical success rates in litigation differ:

- active ingredient patent: 62% brand wins (5% generic)

- follow on patents: 14% brand wins (29% generic)



# Scope of the patent

Previous courts had ruled that paying an entrant to stay out of the market was allowed by the “scope of the patent”

Idea is that patent is legal monopoly

Includes the right to exclude

Paying the generic to exit is therefore legal excluding  
(Logical flaw here – brand shouldn’t need to pay)

Modern patents: great majority are not valid

What is the “scope” of a patent with expected validity  $p=0.1$ ?

IP law intersects with Antitrust law...



# SCOTUS decision

Said that these payments are NOT presumptively legal. Rather, should be considered under rule of reason

- Pay for delay causes harm to consumers
- Brand has incentive and ability to do it
- Not difficult to inquire into the reasonableness (don't need full trial of patent validity)

Dissent: behavior falls within the scope of the patent

- Makes sense in a world where all patents are valid
- Principle gives tremendous market power to anyone who simply files what may be a completely useless patent



# Insurer competition

Individual markets subject to death spiral

ACA may reverse this with mandate

Small group and individual markets

potentially lower transactions costs on exchange

potentially more price competition on exchange

Product is complex

competition may not be a fix on its own

display of info, data to compare

consumers may find choice problem difficult



# MFN contracts

DOJ sued BCBS of MI which had a large share. Complaint alleges insurer said to hospitals:

- We will pay you to take this MFN (price protection clause)
- “You will charge other insurers no less than what BCBS pays”
- “You will charge other insurers at least X% more than you charge BCBS” (X ranged up to 39%)

Harms:

raises price of hospital services

makes entry of other insurers more difficult

reduces innovation in business models (narrow network)



# Resolution

MI passed law outlawing MFNs in healthcare.

DOJ abandoned the lawsuit because that was the remedy the government sought.

Private suits for treble damages still ongoing.

Some other states interested in controlling healthcare costs have passed similar laws

Indiana, Colorado, Maryland,



# Hospital mergers

Old empirical method gave huge markets and tiny market shares => merger wave

=> “typical” market now has 3 hospitals instead of 5 (Gaynor study) due to consolidation

Considerable new literature by academic economists. Current methods of defining a market are more informative.

If a merger causes prices to rise:

consumers on the margin will substitute away (-)

but nearby consumers will pay more (+)

Hospitals can be differentiated both by geography and specialty



# Hospital mergers

Hospital competition has many subtleties.

Who chooses? When? For which service?

The consumer? The primary care physician? The insurer?

Consumers want to be treated at in-network hospitals

Where does hospital competition show up in price?

Insurers forming networks create hospital competition

Hospitals compete NOT to be left out

Value of last hospital to be asked to join network is small

=> price is small.

Suppose the “last” hospital joins a big group. Now it is more costly for an insurer to leave it out => higher price in eqbm



# ACOs and antitrust

“Horizontal” mergers to form an ACO

e.g. two hospitals or two outpatient clinics  
we have just covered the relevant issues

“Vertical” mergers to form an ACO

providers from different parts of the care spectrum  
hospital + rehab + outpatient + physician group

DOJ and FTC will apply antitrust laws as usual and assess  
harms and efficiencies

FTC/DOJ joint policy statement fall 2011

safety zone



# Potential vertical harms

FTC/DOJ note:

Exclusivity might be a warning flag

- An attempt at exclusion of other ACOs?
- An attempt to capture gains from relationship-specific investments?
- An attempt to create higher quality?

Facts will be useful. Liver transplant exclusivity or primary care exclusivity?

Some of these stories make more sense with one type of care than another.



# Potential vertical benefits

## Potential efficiencies from ACOs

- coordination of care
- higher quality of care
- lower cost of care

## How to measure efficiencies?

QALY?

Value of lack of infection?

Note, existence of EMR is not an efficiency, rather what it does to help patients is an efficiency. Need to understand outcomes.



# Assessment

Key issue:

Are efficiencies merger-specific or can they be achieved by some other means that does not harm competition?

For example, can coordination of care incentives be achieved without merging?

Without financial incentives?

How will we weigh the efficiencies against price increases or quality/innovation decreases due to more market power?



Thank you



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