ANTICOMPETITIVE HEALTHCARE

GREGORY DAY[*]

ABSTRACT

American healthcare is known for insufficient competition, high prices, and porous quality. This landscape seems to have not only degraded consumer welfare in general terms but also harmed marginalized communities. As examples, high prices levy greater costs on uninsured people who are more likely to forego treatment while medical bills constitute a primary reason why Americans declare bankruptcy. Helping to explain this state of affairs, hospitals, providers, and doctors adhere to a curious type of practice about prices: there are no prices. By preventing comparison shopping, opacity seems to restrict competition, erect barriers to entry, and enable firms to charge supracompetitive prices. So why hasn't antitrust law scrutinized one of the most anomalous, unique, and perhaps anticompetitive practices in healthcare?

One theory has surfaced that opaque pricing is procompetitive. The assertion is that providers and hospitals would collude (even more) if prices were known; absent knowledge of each other's rates, hospitals cannot supposedly fix them. Put differently, opacity appears to satisfy antitrust law because it is ostensibly the presence of visible prices that enables collusion. Helping to explain this argument's success, some authorities have treated healthcare with an antithetical approach to antitrust's conventional principles in that competition is said to harm patients and consumers. Antitrust courts have even called hospitals "good citizens" who wouldn't abuse their monopoly power. As a result, pricing opacity has largely evaded antitrust scrutiny even though U.S. healthcare bears the traits of an uncompetitive market.

This Article argues that opaque pricing must, in many instances, incur antitrust review. It shows that healthcare markets can seldom support more than a few firms, making collusion more sustainable and achievable. Further, people can rarely avoid buying critical care, which prevents

---

* Associate Professor, Terry College of Business, Courtesy Appointment, School of Law; Affiliated Fellow, Yale Law School Society Information Project. I would like to thank Charlotte Alexander, Ryan Andrews, Michael Carrier, Marc Edelman, Brian Mills, John Newman, Barak Richman, Blaine Sato, Mike Schuster, and Theodosia Stavroulaki for their helpful critiques. In addition, this Article benefitted from comments at the Academy of Legal Studies in Business's Annual Conference in San Diego, CA, and the Junior Faculty Forum at the University of Richmond School of Law. It also received a generous Terry-Sanford Research Award. I'd also like to thank the *Washington University Law Review* for their outstanding work on this Article.

markets from self-correcting and enables providers to charge supracompetitive premiums. And since most patients make decisions based upon their doctor's guidance, opacity creates informational asymmetries whereby providers can dictate prices and prescribe unnecessary treatments. In essence, this Article sheds light on how pricing opacity impedes competition, helping to explain the high prices, waste, and inequities plaguing U.S. healthcare.

TABLE OF CONTENTS

I. ANTICOMPETITIVE HEALTHCARE VIA HISTORICAL LENS.................1547
II. COLLUSION, PRICE OPACITY, AND ITS CONSEQUENCES..................1552
A. *Opaque Pricing and the Anticompetitive Effects* 1552
B. *Indirect Restraints of Trade*...1558
C. *Anticompetitive Effects in Healthcare Markets*..........................1559
III. THE LONGSTANDING FAILURE OF ANTITRUST IN HEALTHCARE MARKETS 1562
A. *The Evolution of Modern Antitrust, Briefly Explained*...............1563
B. *The Failure of Antitrust Enforcement in Healthcare*.................1565
C. *Modern Efforts to Foster Transparency*....................................1569
IV. THE PROMISE OF HEALTHCARE ANTITRUST..................................1570
A. *Healthcare's Pricing Opacity Is Anticompetitive* 1570
1. *It's Exclusionary* 1571
2. *It's Especially Problematic* 1574
3. *Other Anticompetitive Structures of Opacity Under Antitrust Law* 1579
B. *Implications* 1583
1. Parker *Immunity* 1583
2. *Access to Healthcare*...1585
3. *Extension to Non-Health Care Markets*...................................1586
CONCLUSION...1587
APPENDIX...1588

INTRODUCTION

American healthcare is devoid of competition.[1] Many urban hospital markets qualify as monopolies or duopolies while competition is worse outside of cities where mergers have shuttered facilities to the degree that twenty percent of rural counties lack a single hospital.[2] Not only is the

---

1. *See* Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html [https://perma.cc/4JP4-NTZP] ("The mergers have essentially banished competition and raised prices for hospital admissions in most cases, according to an examination of 25 metropolitan areas with the highest rate of consolidation from 2010 through 2013, a peak period for mergers.").

2. Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFFS. 1530, 1533 (2017); Emily Gee & Ethan Gurwitz, *Provider Consolidation Drives up Health Care Costs*, CTR. FOR AM. PROGRESS (Dec. 5, 2018), https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/ [https://perma.cc/4P67-YAAP] ("Rural areas of the country also suffer from scant competition, though concentration in those communities often results from too few providers rather than consolidation. About 1 in 5 rural counties has no hospital at all, and half lack a hospital with obstetric services. In 1980, the country had 5,830 community hospitals; the most recent count is 4,840." (footnotes omitted)).

market for health insurance considered "highly concentrated,"[3] but most urban areas fit the description of uncompetitive when accounting for all forms of healthcare providers.[4]

Without adequate competition, the price of healthcare has increased while quality has declined.[5] To illustrate, American healthcare is the world's most expensive, with an average cost of over $10,000 per person per year—a figure that has more than doubled since 1984.[6] Each year, healthcare bills send one in five people to debt collections[7] and cause more bankruptcies than any other factor.[8] The greatest inequities are felt by low-income communities; as an example, some hospitals recoup discounts given to large insurance companies by charging uninsured persons a steeper rate.[9] Further, many of the 28.9 million people in the United States who lack insurance will forego treatment due to their inability to pay high prices.[10] Four out of

3. AM. MED. ASS'N, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS 2 (2020), https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf [https://perma.cc/567X-MVHQ].

4. Fulton, *supra* note 2, at 1533.

5. Abelson, *supra* note 1; *see also* William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 617 (2016) ("Vigorous demand for health care, meaning both willingness and ability to pay for it in private marketplaces, should create strong incentives for capable supply: high output, competitive prices, quality, choice, and innovation. This has not happened."); Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, N.Y. TIMES (May 14, 2018), https://www.nytimes.com/2018/05/14/upshot/medical-mystery-health-spending-1980.html [https://perma.cc/H2SJ-E5VD] ("The United States devotes a lot more of its economic resources to health care than any other nation, and yet its healthcare outcomes aren't better for it. . . . In 1980, the U.S. was right in the middle of the pack of peer nations in life expectancy at birth. But by the mid-2000s, we were at the bottom of the pack.").

6. William H. Shrank, Theresa L. Rogstad & Natasha Parekh, *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, 322 JAMA 1501, 1503 (2019); Megan Leonhardt, *Americans Now Spend Twice as Much on Health Care as They Did in the 1980s*, CNBC (Oct. 9, 2019, 8:30 AM), https://www.cnbc.com/2019/10/09/americans-spend-twice-as-much-on-health-care-today-as-in-the-1980s.html [https://perma.cc/JNQ2-VMRK].

7. BERNETA L. HAYNES & BETH STEPHENS, GEORGIA WATCH, GEORGIA CONSUMER GUIDE FOR MEDICAL BILLS AND DEBT (2017), https://www.georgiawatch.org/wp-content/uploads/2017/02/medical-debt-guide_final.pdf [https://perma.cc/9SE9-NK8P] ("More than 50% of collection items on credit reports are for medical debt and nearly one in five (19.5%) consumers with a credit report show a medical bill in collections.").

8. Ed Woods, *Health Care Costs Number One Cause of Bankruptcy for American Families*, AM. BANKR. INST., https://www.abi.org/feed-item/health-care-costs-number-one-cause-of-bankruptcy-for-american-families [https://perma.cc/DRA3-C3GM]; *see also* Frank Griffin, *Fighting Overcharged Bills from Predatory Hospitals*, 51 ARIZ. ST. L.J. 1003, 1006 (2019) (discussing the relationship between healthcare bills and bankruptcies).

9. *See infra* notes 91–93 and accompanying text (describing price discrimination).

10. *See* Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, AM. BAR Ass'n, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/ [https://perma.cc/ZF43-XVMD] (describing the inequities of U.S. healthcare in terms of prices and quality); Jennifer Tolbert, Patrick Drake & Anthony Damico, *Key Facts About the Uninsured Population*, KFF (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/NHU8-3YZ9].

ten Americans declined to seek care in 2020 because of out-of-pocket costs.[11]

A potential reason for why U.S. healthcare appears so uncompetitive is a curious type of practice that may undermine price competition: there are no prices.[12] Since a patient must typically agree to pay the "regular rates and terms" instead of a disclosed dollar amount, people will often undergo care before learning of its costs.[13] But in almost every other industry, firms use (low) prices to compete for consumers. This rejection of pricing has seemingly enabled healthcare providers to charge supracompetitive rates while many patients can neither predict nor control their expenses.[14]

So why doesn't antitrust law scrutinize one of the most anomalous and potentially anticompetitive acts in healthcare? Making this issue especially confounding, opaque pricing might restrict competition and manipulate prices in a similar way as price fixing, which antitrust condemns as per se illegal due to its lack of procompetitive justifications. Further, opacity can render a host of downstream issues that would seem impossible under competitive conditions. For instance, a "surprise bill" can occurr without prices where insurance is expected to cover one's treatment yet, after undergoing care, a patient may incur an unexpected, out-of-pocket charge (sometimes in excess of $100,000), portending the bankruptcies derived from healthcare.[15]

Compounding matters, some commentators have pressed a remarkable theory about why opaque pricing is procompetitive. The assertion is that providers and hospitals would collude if prices were known; absent

---

11. Reed Abelson, *Higher Bills Are Leading Americans to Delay Medical Care*, N.Y. TIMES (Feb. 16, 2023), https://www.nytimes.com/2023/02/16/health/inflation-delayed-health-care.html [https://perma.cc/R5C5-Z7M5] ("The inability to afford medical tests and treatment, a perennial concern in the United States, began emerging as a much more striking issue last year. Nearly four of 10 Americans said they had put off care in 2022 because of cost, the highest number since Gallup started asking people about delaying care more than 20 years ago. The percentage reporting they or a family member delayed health care because of cost rose to 38 percent from 26 percent in 2021.").

12. Anna Wilde Mathews, Tom McGinty & Melanie Evans, *How Much Does a C-Section Cost? At One Hospital, Anywhere from $6,241 to $60,584*, WALL ST. J. (Feb. 11, 2021, 8:45 AM), https://www.wsj.com/articles/how-much-does-a-c-section-cost-at-one-hospital-anywhere-from-6-241-to-60-584-11613051137 [https://perma.cc/TS2R-TSJQ] ("The nation's roughly 6,000 hospitals have begun to reveal the secret rates they negotiate with insurers for a range of procedures.").

13. Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 676 (2008) ("After all, the 'plain language of the contract,' which required payment 'in accordance with the rates and terms of the hospital,' left 'the discretion to set the rates solely with the hospital.'" (quoting Cox v. Athens Reg'l Med. Ctr. Inc., 631 S.E.2d 792, 796–97 (Ga. Ct. App. 2006))).

14. Johnny Harris, *I Tried to Find Out How Much My Son's Birth Would Cost. No One Would Tell Me*, VOX (May 5, 2016, 1:50 PM), https://www.vox.com/2016/5/5/11591592/birth-cost-hospital-bills [https://perma.cc/A3PV-MPK3].

15. *See infra* notes 95–101 and accompanying text (explaining the phenomenon of surprise billing).

knowledge of each other's rates, competitors cannot ostensibly fix them.[16] Put differently, opacity doesn't violate antitrust law because it's supposedly *the presence of visible prices* that enables healthcare providers to engage in collusion. Transparency would, as the theory goes, incentivize hospitals and providers to adopt even worse anticompetitive acts, a position that has been suggested by federal antitrust enforcers. Indeed, the Federal Trade Commission (FTC) remarked in 2015 that increasing transparency in healthcare "may chill competition by facilitating or increasing the likelihood of unlawful collusion."[17]

Helping to explain the prevalence of opaque pricing, antitrust had long ignored healthcare. Doctors enjoyed antitrust immunity for about eighty-five years, which reportedly laid the groundwork for today's culture of anticompetitiveness.[18] This landscape has even led some courts and commentators to take an approach to healthcare that is antithetical to conventional antitrust principles in which competition is thought to harm patients and consumers.[19] A fear is that providers might cut quality when competing for price-sensitive patients[20] or that costs could rise if competition forced hospitals to inefficiently compete over quality and offer

---

16. *See, e.g.*, Thomas Sullivan, *New Research Paper Indicates Price Transparency May Not Equate to Lower Prices*, POL'Y & MED. (Aug. 26, 2020), https://www.policymed.com/2020/09/new-research-paper-indicates-price-transparency-may-not-equate-to-lower-prices.html [https://perma.cc/7Z68-VK4G] (citing ROBERT F. GRABOYES & JESSICA MCBIRNEY, MERCATUS CTR., PRICE TRANSPARENCY IN HEALTHCARE: APPLY WITH CAUTION (2020), https://www.mercatus.org/system/files/graboyes-price-transparency-mercatus-research-v1.pdf [https://perma.cc/5SVR-U7YU]).

17. FTC's Off. of Pol'y Plan., Bureau of Competition, and Bureau of Econ., Comment Letter on Amendments to the Minnesota Government Data Practices Act Regarding Health Care Contract Data (June 29, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf [https://perma.cc/RY4D-S8P2] (warning that information exchanges in healthcare may likely allow for collusion); *see also* Castro v. Sanofi Pasteur Inc., 134 F. Supp. 3d 820, 839 (D.N.J. 2015) ("First, the prices in this market are opaque, so firms cannot price coordinate, regardless of what they want."); Margot Sanger-Katz, *Why Transparency on Medical Prices Could Actually Make Them Go Higher*, N.Y. TIMES (June 24, 2019), https://www.nytimes.com/2019/06/24/upshot/transparency-medical-prices-could-backfire.html [https://perma.cc/MRY3-FGJP] ("The reason, scholars concluded, is that there were few manufacturers competing for business. Once companies knew what their competitors were charging, it was easy for them to all raise their prices in concert. . . . 'Collusion is going to be easier when there's a small number of players,' Ms. Starc said."); Brian C. Blase, *Make Transparent Health Care Prices a Price of Any Future Aid to the Health Care Industry*, HEALTH AFFS. (June 16, 2020), https://www.healthaffairs.org/content/forefront/make-transparent-health-care-prices-price-any-future-aid-health-care-industry [perma.cc/3KX6-43QG] (recounting the argument that pricing transparency would enable collusion).

18. *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 787–88 (1975) (ruling that antitrust may scrutinize lawyers and other learned professions).

19. Theodosia Stavroulaki, *Connecting the Dots: Quality, Antitrust, and Medicine*, 31 LOY. CONSUMER L. REV. 175, 177–78 (2019) ("[T]wo underlying ideas dominated healthcare delivery. First, markets fail in healthcare and therefore ordinary market competition is either inappropriate or unachievable in this sector. Second, the medical profession is a self-regulating profession appropriately invested with substantial market power in the healthcare sector." (footnotes omitted)).

20. *See infra* notes 168–71 and accompanying text.

duplicative services.[21] One merger was affirmed when the judge recited that "as a general rule hospital rates are lower, the fewer the number of hospitals in the area."[22] Antitrust courts have also called hospitals "good citizens" who wouldn't think of abusing their monopoly power.[23] After antitrust enforcers lost a series of cases involving hospital mergers in the 1990s, the FTC admitted to turning a blind eye to healthcare during that era.[24]

This Article insists that healthcare's inequities and inaccessibility could lessen if antitrust treated opaque pricing as potentially anticompetitive. The research suggests that opacity can exclude competition and erode consumer welfare in, oftentimes, the same manner as price fixing. But from an antitrust perspective, an initial problem is that courts have yet to acknowledge opaque pricing as exclusionary, much less remedied its dangers.

To support antitrust scrutiny, this Article argues that opaque pricing is more formidable and dangerous than garden variety restraints of trade. Most of the time, markets are expected to self-correct since high prices should attract competition and thereby lower prices without antitrust's help, but this research suggests that opacity in healthcare is unlikely to self-correct while creating greater levels of harm. Because healthcare markets can seldom support more than a few competitors, the lack of collective-action problems is shown to make collusion more robust and sustainable.[25] Courts are also supposed to dial up scrutiny when conduct harms consumers in almost every instance; here, a patient can rarely avoid buying critical care, which impedes markets from self-correcting and enables providers to charge "extortionary premiums."[26] And since most patients must make decisions based on their doctor's guidance, opacity has created informational asymmetries whereby providers can more easily dictate prices and prescribe unneeded treatments.[27] In effect, healthcare's culture of opacity is not only

---

21. *Id.*

22. United States v. Carilion Health Sys., 707 F. Supp. 840, 846 (W.D. Va. 1989).

23. United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997) ("[T]he Court finds that [hospitals] have a genuine commitment to help their communities."); Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 LOY. U. CHI. L.J. 643, 643–44 (2017) ("It is increasingly hard to say with a straight face that these general principles apply when the antitrust laws are applied to the health care sector.").

24. *See* Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 64 (2016) ("Furthermore, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have largely focused their antitrust policy guidance and review on horizontal provider consolidation, further encouraging providers to integrate vertically.").

25. *See* C. Scott Hemphill & Tim Wu, *Parallel Exclusion*, 122 YALE L.J. 1182, 1191–92 (2013) (explaining the greater chances of collusion with fewer firms in a market).

26. Gregory Day, *The Necessity in Antitrust Law*, 78 WASH. & LEE L. REV. 1289, 1345 (2021) (explaining the problems of anticompetitive conduct in markets of necessities).

27. *See infra* notes 102–07 and accompanying text (describing the recommendation of stents in legs which seems to entail a largely unnecessary procedure).

exclusionary but could even negate antitrust's deference.[28] This Article concludes that opacity helps to shed light on healthcare's high prices and low quality.

That said, antitrust's treatment of healthcare may have reached a breaking point. Enforcers have recently begun to spend significant resources on healthcare, buoyed by articles in the *New York Times* and *Wall Street Journal* about opaque prices.[29] A partnership was also announced in 2022 between the Department of Justice Antitrust Division (DOJ) and the Department of Health and Human Services seeking to inject competition into healthcare as a way of boosting national health.[30] Further, Commissioner Rebecca Slaughter of the FTC recently emphasized the dangers of healthcare monopolies for society's least powerful:

> One area I think about in antitrust all the time is health care. . . . We focus on it because access to health care is important to people. But when you drill down even further, it's not just that all people need access to health care. It is more difficult for lower income people to bear increased marginal costs in health care, or to overcome lack of access for the challenges faced by lack of competition, and because we also know that lower-income people are disproportionately people of color . . . .[31]

The agencies have even claimed recent wins in the healthcare sector.[32] As high costs and low quality become evident, a belief has emerged among

---

28. Georgina Adam, *How Transparent Is the Art Market?*, FIN. TIMES (Apr. 28, 2017), https://www.ft.com/content/77cba886-251b-11e7-a34a-538b4cb30025 [https://perma.cc/GF7W-C3RT]; *see also* Tim Schneider, *The Gray Market: Why Opaque Pricing in the Gallery Sector Makes Museum Collections Less Diverse (and Other Insights)*, ARTNET (Sept. 23, 2019), https://news.artnet.com/opinion/price-transparency-museum-diversity-1658107 [https://perma.cc/XB8N-NU6X].

29. *See, e.g.*, Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why*, N.Y. TIMES (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html [https://perma.cc/92UD-XJAP]; Dan Diamond, *Nearly All Hospitals Flout Federal Requirement to Post Prices, Report Finds*, WASH. POST (July 16, 2021, 2:42 PM), https://www.washingtonpost.com/health/2021/07/16/hospital-cost-transparency/ [https://perma.cc/XJ55-AWLJ].

30. Press Release, DOJ, Off. of Pub. Affs., Justice Department's Antitrust Division and the Office of the Inspector General of the Department of Health and Human Services Announce Partnership to Protect Health Care Markets (Dec. 9, 2022), https://www.justice.gov/opa/pr/justice-department-s-antitrust-division-and-office-inspector-general-department-health-and [https://perma.cc/3KDW-UJLM].

31. Lauren Feiner, *How FTC Commissioner Slaughter Wants to Make Antitrust Enforcement Antiracist*, CNBC (Sept. 26, 2020, 10:45 AM), https://www.cnbc.com/2020/09/26/ftc-commissioner-slaughter-on-making-antitrust-enforcement-antiracist.html [https://perma.cc/FKW4-97MB].

32. *See infra* notes 189–94 and accompanying text.

liberal and conservative commentators alike that antitrust's treatment of healthcare must undergo an overhaul; the question is how.[33]

In fact, pricing opacity—which has long been cabined to healthcare and ignored by enforcers—is primed to become a pressing antitrust problem in other markets due to the rise of digital platforms. Antitrust courts have recently opined that the manner in which platforms conceal prices has made transparent information even more important in competitive markets.[34] So while opacity is best known in healthcare, the issue may soon challenge antitrust courts, enforcers, and scholars as digital platform companies innovate ways of shrouding prices and charging supracompetitive rates.

This Article proceeds in four Parts. Part I traces the evolution of U.S. healthcare, which is known for high prices, low quality, and insufficient rates of insurance. When Congress attempted to improve this system, it enacted legislation that seems to have made it easier for providers to collude as well as raise prices. Part II discusses the lack of competition plaguing healthcare and why this landscape has produced opaque pricing and related ills. Part III delves into antitrust law and its application to healthcare, discussing enforcement's historical failures as well as theories that have prevailed for why providers and hospitals should essentially be immune from antitrust litigation. It notes that antitrust commenators have specifically sought to justify opaque pricing as procompetitive conduct on the grounds that transparency would actually enable collusion. Part IV makes the case that opaque pricing is akin to price fixing, arguing that enforcers and courts should begin to scrutinize anticompetitive practices in healthcare markets. To this end, they should first recognize that opaque pricing explains much of the inequity and waste found in modern healthcare.

I. ANTICOMPETITIVE HEALTHCARE VIA HISTORICAL LENS

This Part attributes some of U.S. healthcare's lack of competition to historical events. Few people visited hospitals until the 1940s at which time employers began to offer insurance. Due to employer-based policies, the quality of healthcare increased as well as demand for it. But a couple of problems arose too: high prices and relatively low rates of insurance. This prompted Congress in 2010 to enact landmark legislation in the form of the Affordable Care Act (ACA), which sought to increase insurance rates, catalyze mergers, reduce the number of competitors, and thus boost

---

33. Les Masterson, *Lack of Provider Competition Raising Healthcare Prices, Center for American Progress Argues*, HEALTHCARE DIVE (Dec. 6., 2018), https://www.healthcaredive.com/news/lack-of-provider-competition-raising-healthcare-prices-center-for-american/543702/ [https://perma.cc/KL32-SCLY].

34. Epic Games, Inc. v. Apple Inc., 559 F. Supp. 3d 898, 1031–32 (N.D. Cal. 2021), *aff'd in part*, *rev'd in part*, *and remanded*, 67 F.4th 946 (9th Cir. 2023).

efficiency. As such, the following Part explores the history of U.S. healthcare to understand its modern problems.

In the early days of American healthcare, charities operated most hospitals while doctors practiced from their homes, in theaters, or at other non-hospital venues.[35] Rather than curing diseases, doctors tended to promote comfort by prescribing opiates.[36] And medicine was hardly a lucrative profession, as many doctors incurred greater costs than they could recoup, forcing them to provide care on credit[37] or work second jobs.[38] Given healthcare's low quality, hospitals played only a minor role in society's health: "Almost no one who had a choice sought hospital care. Hospitals were regarded with dread, and rightly so."[39] Historically, medicine was considered a charitable and rudimentary venture.[40]

U.S. Healthcare evolved when employers started to issue insurance. The watershed moment occurred in 1929 when Baylor University's Medical College created insurance policies for ranchers and employees of the *Dallas Morning News*.[41] This generated such enthusiasm that companies in other states began to insure workers in programs known as "Blue Cross" plans.[42] When the Stabilization Act of 1942 froze salaries, employers sought to provide employees with Blue Cross Plans in lieu of monetary raises.[43] The value of insuring employees led President Roosevelt to make health benefits non-taxable via executive order, turning Blue Cross plans into the primary

35. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 61, 63–65 (2017).

36. Peter A. Ubel, *Can Patients in the United States Become Savvy Health Care Consumers?*, 92 N.C. L. REV. 1749, 1751 (2014).

37. ELISABETH ROSENTHAL, AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK 14 (2017) ("Often run by religious charities, hospitals were places where people mostly went to die."); STARR, *supra* note 35, at 63.

38. STARR, *supra* note 35, at 63, 65–66, 80 ("Much medical care was provided on credit. Physicians tried to collect their fees quarterly or annually, but they lost a substantial portion of their income through unpaid bills. The credit system, like contract practice, was a source of much irritation to doctors, but they were in no position to eliminate it. . . . Many physicians found it extremely difficult to support themselves solely from medical practice. A second occupation, usually farming, often proved necessary. . . . [T]he real price of medical care was so much higher than their fees.").

39. *Id.* at 72.

40. *Id.* at 61 ("English law regarded the services of physicians as wholly philanthropic.").

41. ROSENTHAL, *supra* note 37, at 15–16.

42. *Id.*

43. Aaron E. Carroll, *The Real Reason the U.S. Has Employer-Sponsored Health Insurance*, N.Y. TIMES (Sept. 5, 2017), https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html [https://perma.cc/8EYK-USTS] ("In 1942, with so many eligible workers diverted to military service, the nation was facing a severe labor shortage. Economists feared that businesses would keep raising salaries to compete for workers, and that inflation would spiral out of control as the country came out of the Depression. To prevent this, President Roosevelt signed Executive Order 9250 establishing the Office of Economic Stabilization. This froze wages. Businesses were not allowed to raise pay to attract workers. Businesses were smart, though, and instead they began to use benefits to compete. Specifically, to offer more, and more generous, health care insurance.").

means of insuring people.[44] The rate of insured Americans increased from ten percent in 1940 to sixty percent in 1955.[45]

Healthcare's quality improved as insurance injected cash into this sector.[46] For instance, Congress passed Medicare in 1965 to benefit elderly people whose employer-based plans expired; this encouraged investments in medicine, treatments, and technology, which rendered X-Ray machines, pharmaceuticals, and other devices enabling doctors to cure formerly lethal afflictions.[47] Demand for hospitals swelled as survival rates increased.[48]

It is perhaps predictable that some of healthcare's problems would surface as hospitals evolved into lucrative businesses.[49] By the mid-1980s, hospitals began to hire MBAs, contracted with consultants, and employed other professionals tasked with raising revenue.[50] Contrary to how aspects of healthcare had historically lost money—in fact, charitable hospitals had typically charged non-profitable rates or even nothing—facilities like emergency rooms and drug treatment centers were now expected to profit.[51] Highlighting the money in modern healthcare, the top grossing non-profit

---

44. ROSENTHAL, *supra* note 37, at 16; *see also* Kathleen Snow Sutton, *Wait Then Reassess: Antitrust Risks of Vertical Integration in Healthcare Remain an Open Question*, 96 DENV. L. REV. 353, 356 (2019) ("In 1973, Congress passed the Health Maintenance Organization Assistance Act (HMO Act), which exempted 'federally qualified' health maintenance organizations (HMOs) from state insurance laws to encourage the development of organized healthcare delivery systems. The HMO Act, combined with rising healthcare costs, encouraged the development of alternative prepaid models, under which employers would pay a fixed monthly amount per covered employee in exchange for a full range of medical benefits." (footnote omitted)); Stephen Mihm, *Employer-Based Health Care Was a Wartime Accident*, CHI. TRIB. (Feb. 24, 2017, 3:30 PM), https://www.chicagotribune.com/opinion/commentary/ct-obamacare-health-care-employers-20170224-story.html [https://perma.cc/V8TT-RE97] (discussing the accidental history of Blue Cross Plans).

45. ROSENTHAL, *supra* note 37, at 17.

46. Ubel, *supra* note 36, at 1754–55 ("[T]he enactment of Medicare created a huge influx of government money, allowing hospitals and physicians in the United States to spend freely on constructing new buildings and clinics, confident that there would be plenty of paying customers to recoup these investments.").

47. *Id.* at 1752–55.

48. *Id.* at 1752 ("Amidst this burgeoning technology, the modern hospital industry began to arise, building imposing structures substantial enough to house all this new medical equipment, and filled with enough beds to care for the many patients whose previously fatal diagnoses were now transformed into lengthy hospital stays." (footnote omitted)); STARR, *supra* note 35, at 145 ("Few institutions have undergone as radical a metamorphosis as have hospitals in their modern history. In developing from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order, they acquired a new moral identity, as well as new purposes and patients of higher status.").

49. STARR, *supra* note 35, at 159 ("Hospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue."); *id.* at 173 ("The public and private hospitals also functioned as alternative systems of patronage and sponsorship. At elite private hospitals, as we have already seen, wealthy patrons sponsored the admission of patients to free beds, and staff appointments went to physicians from established families, while Catholics and Jews were passed over."); *see also* Ubel, *supra* note 36, at 1753 ("[E]xpenditures rose 10.6% during the 1960s, 13.1% during the 1970s, and 11% during the 1980s.").

50. ROSENTHAL, *supra* note 37, at 32–33.

51. *Id.* at 39, 154.

organization in most cities is a hospital while the highest paid non-profit CEO is similarly a hospital executive.[52] An issue emerged, though, in that private insurers could avoid covering high-cost and high-risk patients such as low-income individuals, elderly people, and those with pre-existing conditions.

Since many Americans continued to lack insurance into the early 2000s while costs mounted, Congress responded with the ACA.[53] The legislation endeavored to create a marketplace in which insurers could no longer exclude elderly patients or those with preexisting conditions.[54] By incentivizing insurers to enter this market with tax credits and subsidies, the hope was that people could comparison shop among plans.[55] And the ACA was successful in substantially improving insurance rates in the United States. That said, requiring insurers to cover "low value" patients pressured hospitals into merging, which eroded competition even further.[56] One dynamic was that insurers sought to lessen the risk of accepting high-risk (and thus costly) patients by increasing their enrollments, leading them to

52. *Id.* at 47–48.

53. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). *See generally* Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 578 (2020) (describing the ACA).

54. *See* Erin C. Fuse Brown, *Developing A Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 475 (2013) ("The ACA's right to health care relies upon market competition, an increase in the pool of those with insurance and several other indirect mechanisms to keep premium prices for health insurance offered in the Exchanges under control. The removal of a government-offered 'public option' health plan from the final bill eliminated an additional tool to foster competition and exert downward pressure on prices in the Exchanges. With Medicare, by contrast, the government is the payer and can set its prices and implement payment and health care delivery reforms to try to keep its costs down." (footnotes omitted)).

55. David Cusano & Kevin Lucia, *Implementing the Affordable Care Act: Promoting Competition in the Individual Marketplaces*, COMMONWEALTH FUND (Feb. 4, 2016), https://www.commonwealthfund.org/publications/issue-briefs/2016/feb/implementing-affordable-care-act-promoting-competition [https://perma.cc/XF8G-APSM] ("The law encourages insurers in the individual market to compete in a variety of ways. For instance, to obtain federal subsidies, eligible consumers must purchase coverage through the marketplaces. This provides an incentive for insurers who want to gain access to those potential customers to offer marketplace coverage. Additionally, the tax credits offered are based on a benchmark plan—that is, the second-lowest-cost silver plan available on the marketplace—and consumers shop for plans by comparing the benchmark plan to other plans. This ability to comparison shop encourages insurers to compete on price and value. Finally, as a safeguard against unreasonable premium hikes, the states are required to review premium rate increases to ensure that such increases are reasonable.").

56. *See, e.g.*, Jake Miller, *Hospital Mergers and Quality of Care*, HARV. MED. SCH. (Jan. 16, 2020), https://hms.harvard.edu/news/hospital-mergers-quality-care [https://perma.cc/846M-5ZPL]; Sutton, *supra* note 44, at 359 ("The ACA initiated a movement towards coordinated care and value-based payments, which require increased scale and expensive medical-record technology to survive the price pressures, which encouraged a surge in consolidation. Merger activity in the healthcare industry has skyrocketed, and remained active, since the passage and implementation of the ACA, with fifteen straight quarters of 200 or more health-services mergers and acquisitions. Hospital and health-system transactions reached a record 115 deals in 2017 . . . ." (footnotes omitted)).

acquire smaller insurers.[57] This was not an unexpected event, as the ACA's architects sought to spark acquisitions in hopes of cutting spending, standardizing treatments, and fostering efficiencies.[58] As one journalist observed,

> [t]he central planners behind the Affordable Care Act—also known as Obamacare—were convinced that consolidation in health care would lead to decreased health care spending by eliminating duplication, standardizing treatment protocols and incentivizing better utilization. As three of Obamacare's primary authors wrote in The Annals of Internal Medicine in 2010, the law was designed to "unleash forces that favor integration across the continuum of care." No part of health care was supposed to be spared—doctors, hospitals, insurers, pharmaceutical companies and others were given regulatory and financial incentives to merger.[59]

Mergers of hospitals increased from 76 in 2010 to 115 in 2017—the most in recent history[60]—trimming the number of competitors in many markets.[61] And this occurred after a merger wave in the 1990s. The results have been mixed where scholars found that some hospital mergers increased efficiency,[62] yet the overall trend of acquisitions as well as specific types of mergers seems to have harmed some people's overall health and increased prices.[63]

Similar to Congress's efforts, states have combined with lobbyists to lessen healthcare competition. For instance, legislatures have recently

---

57. Catherine Ho, *Affordable Care Act Driving Health Care Mergers*, WASH. POST (Aug. 26, 2012, 4:33 PM), https://www.washingtonpost.com/business/capitalbusiness/affordable-care-act-driving-health-care-mergers/2012/08/24/95d5601c-ec9d-11e1-a80b-9f898562d010_story.html [https://perma.cc/TW3N-2JWW].

58. *See* Maria Ioanna Pantelaki & Chloé White, *Health Care: Access After Health Care Reform*, 15 GEO. J. GENDER & L. 95, 98 (2014) (signaling early optimism that the ACA may decrease healthcare costs); Jeffrey A. Singer, *Obamacare's Catch 22*, U.S. NEWS & WORLD REP. (Aug. 11, 2016, 3:15 PM), https://www.usnews.com/opinion/articles/2016-08-11/obamacare-gave-rise-to-the-health-care-mergers-its-advocates-oppose [https://perma.cc/KK7A-Z9M6].

59. Singer, *supra* note 58.

60. Lawrence E. Singer, *Considering the ACA's Impact on Hospital and Physician Consolidation*, 46 J.L. MED. & ETHICS 913, 914 (2018) ("[T]he passage of the ACA in 2010 accelerated transactions, with 76 transactions in 2010 and 93 in 2011. This trend continued with 100 or more transactions in 2014–2016; in 2017 115 transactions were announced, the highest number in recent history." (footnote omitted)).

61. *Id.*

62. THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS, AND COMPETITION LAW: A SYSTEMATIC APPROACH *48 (2023) ("To the extent that a hospital merger increases patient volumes for hospital providers, and higher volumes can contribute to better performance, a merged hospital entity may in certain cases result in higher quality care.").

63. *See, e.g.*, Arthur H. Gale, *Bigger but Not Better: Hospital Mergers Increase Costs and Do Not Improve Quality*, MO. MED., Jan./Feb. 2015, at 4, 5; Theodosia Stavroulaki, *Mergers that Harm Our Health*, 19 BERKELEY BUS. L.J. 89, 99 (2022).

enacted "certificates of competitive advantages" (COPAs), which permit selected hospitals to merge into a monopoly within a state.[64] While COPAs may appear anticompetitive,[65] states enjoy antitrust immunity (explained in Part III).[66]

The point of the above discussion is not to criticize the ACA. It has indeed increased insurance rates and benefitted numerous people who were historically excluded from healthcare—but the legislation has also helped to lessen competition. Not only do many aspects of U.S. healthcare qualify as uncompetitive but this landscape has also, according to the next Part, enabled hospitals and providers to implement opaque pricing.[67]

II. COLLUSION, PRICE OPACITY, AND ITS CONSEQUENCES

Healthcare's lack of competition has seemingly assuaged several types of anticompetitive practices. While a restraint of healthcare like an anti-steering clause may indirectly restrict competition, other arrangements are apparently intended to avoid price competition. By specifically concealing prices, providers can potentially elevate rates above market levels and render a host of derivative problems such as surprise billing. To make these points, Section A explores opaque pricing and Section B canvasses indirect types of restraints. Then Section C details the anticompetitive effects of insufficient competition.

A. Opaque Pricing and the Anticompetitive Effects

A remarkable practice in American healthcare involves opaque pricing because it can seemingly suppress competition as well as create problems such as surprise billing, price discrimination, and informational asymmetries. To help explain the emergence of pricing opacity, it was

---

64. Press Release, FTC, FTC to Study the Impact of COPAs (Oct. 21, 2019), https://www.ftc.gov/news-events/news/press-releases/2019/10/ftc-study-impact-copas [https://perma.cc/4YUH-6RCV]; David R. Garcia & Joseph Antel, *Sixth Circuit Questions Efficacy of State "Certificate of Need" Laws, Question Whether Reduces Competition*, NAT'L L. REV. (Mar. 7, 2022), https://www.natlawreview.com/article/sixth-circuit-questions-efficacy-state-certificate-need-laws-question-whether [https://perma.cc/6XZU-KK49].

65. *See* Press Release, FTC, *supra* note 64; *see also* Gregory Day, *State Power and Anticompetitive Conduct*, 75 FLA. L. REV. 637, 657 (2023) ("COPAs [have] raise[d] prices, reportedly forcing uninsured people into choosing whether to pay monopoly rates *out of pocket* or decline receiving treatment, yet hospitals and providers have successfully persuaded states to enact COPAs." (emphasis added)).

66. *See* Parker v. Brown, 317 U.S. 341 (1943).

67. Asher Schechter, *The True Price of Reduced Competition in Health Care: Hospital Monopolies Drastically Drive Up Prices*, PROMARKET (Mar. 14, 2016), https://promarket.org/2016/03/14/the-true-price-of-reduced-competition-in-health-care-hospital-monopolies-drastically-drive-up-prices/ [https://perma.cc/X7UR-DTYC].

originally the case that Blue Cross and Blue Shield[68] plans paid the same rates as uninsured persons when reimbursing doctors and hospitals based on a treatment's cost plus a premium of about 10%.[69] But this created incentives for hospitals and doctors to increase prices in pursuit of greater premiums.[70] And since Medicare and Medicaid paid only a fraction of what private insurers were charged, hospitals encountered incentives to raise their prices even more as well as seek different rates from different payors such as uninsured individuals, private insurers, or Medicaid.[71] Inspired by the lower rates given to Medicare, private insurers began to bargain for discounted prices in the 1980s.[72] As insurers became less likely to pay the sticker, opaque pricing arose as an attractive option for both providers and insurers; after all, not only were providers able to sell care to patients without disclosing prices—since insurers would ultimately pay the bill[73]—but large insurers also believed that the process of secretly bargaining rates offered them a competitive advantage.[74] This has led insurers to enter

68. Blue Shield plans differ from Blue Cross plans in that doctors devised Blue Shield policies as a way of setting their own prices rather than allowing hospitals to establish prices via Blue Cross plans. Elisabeth Rosenthal, *Insurance Policy: How an Industry Shifted from Protecting Patients to Seeking Profit*, STAN. MED. MAG. (May 19, 2017), https://stanmed.stanford.edu/how-health-insurance-changed-from-protecting-patients-to-seeking-profit/ [https://perma.cc/S7GB-8TRT].

69. Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11, 18 (2014) ("The chargemaster originated in the 1930s along with the advent of health insurance, which routinely paid a hospital's charges—then calculated as the hospital's cost of providing the service plus about ten percent. Everyone, whether insured or not, paid the same chargemaster rates." (footnote omitted)); *see also* George B. Moseley III, *The U.S. Health Care Non-System, 1908-2008*, 10 AMA J. ETHICS 324, 326 (2008).

70. Moseley, *supra* note 69, at 326 ("In this payment scheme, physicians were compensated according to 'reasonable and customary charges' that they themselves set, and hospitals were reimbursed on a percentage of their actual costs plus a percentage of their working and equity capital. This allowed doctors to charge whatever they wanted and encouraged hospitals to increase costs so their cost-based income would be greater. This methodology was replicated by commercial insurers and the subsequent government health insurance programs, Medicare and Medicaid.").

71. *Id.* at 326–27 ("Overnight the federal government became the largest single purchaser of health care services, but these two public programs adopted the same reimbursement defects that were found in the private health insurance industry, accelerating the rate of health care price inflation."); Bill Hennessey, *The History of Secret Medical Pricing*, LINKEDIN PULSE (Sept. 19, 2017), https://www.linkedin.com/pulse/history-secret-medical-pricing-bill-hennessey-m-d-/ [https://perma.cc/7D2F-78YF] ("And then things changed. In the 1970s, Medicare paid hospitals for medical care based on a percentage of their chargemasters, which is the list of retail pricing for everything a hospital charges, ranging from a pill to a surgery tray to a physician's services. Hospital administrators knew that each year Medicare would reimburse a lesser percentage of their chargemasters, so they raised their chargemaster fees more to make sure they fed more money into their hospitals.").

72. Fuse Brown, *supra* note 69, at 14, 17–19.

73. Tom Coburn, *Here's Why Price Transparency Can Revolutionize Health Care*, MANHATTAN INST. (Oct. 11, 2019), https://www.manhattan-institute.org/price-transparency-can-revolutionize-health-care [https://perma.cc/K2KL-ZAEU].

74. *See* Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFFS. 45, 46 (2006).

confidentiality agreements[75] as well as assert that their prices constitute trade secrets.[76] Today, most patients must agree to pay non-disclosed prices charged by providers before receiving care—per the ordinary contract, a patient "obligates himself . . . to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital."[77] Even if a hospital offers an estimate, the quote is generally considered nonbinding.[78] And without transparency, most patients cannot seek out cheaper options[79]—indeed, "a consumer typically has no idea what it will cost until after she has consumed the service and receives the bill."[80]

While insurance companies would seemingly benefit from bargaining down prices, it is often more profitable for insurers to accept the greatest volume of transactions.[81] A similar issue is that insurers can charge employers for their workers' care, severing the insurers' incentives to negotiate rates with hospitals; it was observed that "Colorado employers were shocked to learn they were paying nearly eight times what the federal

75. Fuse Brown, *supra* note 69, at 22 ("Typically the negotiated prices are subject to contractual confidentiality requirements and treated as trade secrets. This not only limits the degree to which competitors can access a health plan's negotiated rates with a hospital, but also results in insuperable price opacity for patients." (footnote omitted)); *see also* Anna Wilde Mathews, *Behind Your Rising Health-Care Bills: Secret Hospital Deals that Squelch Competition*, WALL ST. J. (Sept. 18, 2018, 10:46 AM), https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963?st=swk5jg1os6qoa7a&reflink=article_email_share [https://perma.cc/M6HK-T7EQ] ("The effect of contracts between hospital systems and insurers can be difficult to see directly because negotiations are secret. The contract details, including pricing, typically aren't disclosed even to insurers' clients—the employers and consumers who ultimately bear the cost."); *In re* Pharm. Indus. Average Wholesale Price Litig., 491 F. Supp. 2d 20, 40 (D. Mass. 2007) (discussing contracts mandating opacity in the pharmaceutical industry), *aff'd*, 582 F.3d 156 (1st Cir. 2009).

76. Joshua Cohen, *U.S. Healthcare Markets Lack Transparency; Stakeholders Want to Keep It That Way*, FORBES (Dec. 7, 2020, 10:11 AM), https://www.forbes.com/sites/joshuacohen/2020/12/07/us-healthcare-markets-lack-transparency-stakeholders-want-to-keep-it-that-way/?sh=3202163662b2 [https://perma.cc/V8LR-HPJR].

77. Wendy Netter Epstein, *Price Transparency and Incomplete Contracts in Health Care*, 67 EMORY L.J. 1, 2 (2017); *see also Consent for Admission and Treatment*, OCH REG'L MED. CTR., https://www.och.org/wp-content/uploads/2020/06/OCH-176_Consent_for_Admission_and_Treatment_fillable.pdf [https://perma.cc/57ZF-QXZE].

78. *See generally* Jaime S. King & Erin C. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 43 (2017).

79. Sammy Mack, *They Paid How Much? How Negotiated Deals Hide Health Care's Cost*, NPR (Nov. 15, 2014, 7:48 AM), https://www.npr.org/sections/health-shots/2014/11/15/364064088/they-paid-how-much-how-negotiated-deals-hide-health-cares-cost [https://perma.cc/K62Y-KUQ2].

80. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 156 (2017).

81. Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why.*, N.Y. TIMES: THE UPSHOT (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html [https://perma.cc/8CJZ-J4Q9] ("Customers judge insurance plans based on whether their preferred doctors and hospitals are covered, making it hard for an insurer to walk away from a bad deal. The insurer also may not have a strong motivation to, given that the more that is spent on care, the more an insurance company can earn."); Fuse Brown, *supra* note 69, at 21 ("Providers accept the discounted rates in exchange for the increased volume of patients they will receive as a result of being a contracted (in-network) provider.").

government did for outpatient services like an emergency room visit, an X-ray or a checkup with a specialist."[82] And naturally, insurers in certain regions can struggle to lower rates, given the hospitals' market power; after all, insurers cannot operate without the hospitals and thus cannot effectively bargain down prices.

Since providers can ex post set prices, healthcare costs vary wildly. Take a knee replacement surgery.[83] One article by the *Wall Street Journal* concluded that the procedure's price is divorced from competitive forces but set by each hospital's profitability goals.[84] Different providers may indeed charge drastically different rates for identical knee surgeries—as much as $50,000 or as little as $7,000.[85] Another example is COVID-19 testing: a report in 2020 found that hospitals demanded a range of prices including $0, $2,715, $4,000, $8,884.16, and $10,984 per test,[86] a wide array of rates for a minimal procedure costing hospitals about $8 in materials.[87] The price to use a ventilator at George Washington University Hospital amounts to $115,000 but costs only $53,000 down the street at Providence Hospital; the *Washington Post* has reported similar examples.[88]

Because a good's price in a competitive market should theoretically converge on its marginal cost,[89] the arrays of rates suggest that healthcare

---

82. Reed Abelson, *Many Hospitals Charge Double or Even Triple What Medicare Would Pay*, N.Y. TIMES (May 9, 2019), https://www.nytimes.com/2019/05/09/health/hospitals-prices-medicare.html [https://perma.cc/LV7N-J97A].

83. Melanie Evans, *What Does Knee Surgery Cost? Few Know, and That's a Problem*, WALL ST. J. (Aug. 21, 2018, 11:29 AM), https://www.wsj.com/articles/what-does-knee-surgery-cost-few-know-and-thats-a-problem-1534865358?st=vbtvz4mr4tmezhe&reflink=article_email_share [https://perma.cc/36B4-N3HW].

84. *Id.*

85. *Id.* ("[T]he prices paid for the surgery at some hospitals in the U.S. were more than double the prices at others . . . .").

86. Adam Andrzejewski, *A $4,000 COVID Test in Oklahoma Resulted in a Debate on Healthcare Prices and Transparency*, FORBES (Jan. 31, 2021, 11:10 PM), https://www.forbes.com/sites/adamandrzejewski/2021/01/31/a-4000-covid-test-in-oklahoma-resulted-in-a-debate-on-healthcare-prices-and-transparency/?sh=7609bf1476ac [https://perma.cc/NXX5-3X6S].

87. Marshall Allen, *A Doctor Went to His Own Employer for a COVID-19 Antibody Test. It Cost $10,984.*, PROPUBLICA (Sept. 5, 2020, 5:00 AM), https://www.propublica.org/article/a-doctor-went-to-his-own-employer-for-a-covid-19-antibody-test-it-cost-10-984 [https://perma.cc/XB9Z-VPEG].

88. Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 — Another, $38,000*, WASH. POST (May 8, 2013, 12:01 AM), https://www.washingtonpost.com/news/wonk/wp/2013/05/08/one-hospital-charges-8000-another-38000/ [https://perma.cc/37PN-RRDG] ("For a lower joint replacement, George Washington University charged almost $69,000 compared with Sibley Memorial Hospital's average of just under $30,000. Virginia's highest average rate for a lower limb replacement was at CJW Medical Center in Richmond, more than $117,000, compared with Winchester Medical Center charging $25,600 per procedure.").

89. MCI Commc'ns Corp. v. Am. Tel. & Tel. Co., 708 F.2d 1081, 1123 (7th Cir. 1983) ("Where a firm faces competition, demand is more elastic—that is, more sensitive to changes in prices—because of the presence of other firms producing substitute products to which buyers may turn. Lower returns on investment are to be expected in competitive markets because each firm, in accordance with classical competitive theory and practice, will be forced to lower prices toward marginal costs in order to maintain its market share.").

providers operate beyond competition's confines. After all, patients must often trust their doctor about pricing and treatment. And unlike in a competitive market, it is difficult for most patients to predict out-of-pocket bills that may exceed $100,000.[90] While differences in quality can logically affect a good's price, the level of variation within similar regions suggests that a greater dynamic is at play.

Opaque pricing has even created derivative issues such as surprise billing and price discrimination. Instead of negotiating on everyone's behalf, providers are able to discriminate against vulnerable parties.[91] Whereas smaller insurers and uninsured patients must often pay the full rates listed on a hospital's confidential menu of billing codes—known as a "chargemaster"—large insurers are able to bargain these prices down (further explaining why insurers have yet to lower prices for everyone).[92] The effect is that providers can compel uninsured patients to pay, in reported instances, up to ten to twenty times more than insured people as a way of discriminating against less powerful payors.[93] As one scholar described the burden on society's poorest:

> The crazy-quilt phenomenon of some patients paying less and some more for exactly the same care evolved the same way: hospital business departments realized if Medicare or a powerful insurer wouldn't agree to pay a big enough proportion of the rate they wanted, they had the leverage to insist that smaller insurers—and people with no insurance—pay more.[94]

---

90. *See, e.g.*, Melanie Evans & Tom McGinty, *Hospital Prices Are Arbitrary. Just Look at the Kingsburys' $100,000 Bill.*, WALL ST. J. (Oct. 28, 2021, 3:21 PM), https://www.wsj.com/articles/hospital-prices-arbitrary-healthcare-medical-bills-insurance-11635428943 [https://perma.cc/PSP6-RW8K].

91. *See* David Howard, *Insurers Can Reduce Drug Prices, If Policymakers Let Them*, HEALTH AFFS. (July 14, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160714.055854/full/ [https://perma.cc/39AS-D474] (asserting that the power of insurers makes them the best party to lower prices for all consumers); Rebecca Pifer, *Privately Insured Face Worse Access, Higher Costs Than Those in Public Plans: JAMA Report*, HEALTHCARE DIVE (June 1, 2021), https://www.healthcaredive.com/news/privately-insured-face-worse-access-higher-costs-than-those-in-public-plan/600957/ [https://perma.cc/E3Q2-WTDP].

92. ROSENTHAL, *supra* note 37, at 31.

93. Tina Rosenberg, *Revealing a Health Care Secret: The Price*, N.Y. TIMES: OPINIONATOR (July 31, 2013, 10:20 AM), https://opinionator.blogs.nytimes.com/2013/07/31/a-new-health-care-approach-dont-hide-the-price/ [https://perma.cc/2H8T-55T8]; Griffin, *supra* note 8, at 1003 ("Hospitals routinely expect patients to pay different prices for the same services and often ask the most vulnerable patients to pay ten to twenty-five times as much as the hospital routinely accepts as payment in full. For a service that the government allows participating hospitals to charge its patients $117 in 2019 dollars, some hospitals may charge patients up to $3254 for the same service, and most hospitals charge almost $500 for that same $117 service." (footnote omitted)).

94. ROSENTHAL, *supra* note 37, at 31; *see also* Theodosia Stavroulaki, *The Healing Power of Antitrust*, 119 NW. U. L. REV. __ (forthcoming 2025) (discussing antitrust's ability to promote the health of especially low-income persons).

Opaque pricing is also linked to surprise billing.[95] This phenomenon occurs when an aspect of a patient's procedure falls outside of their insurance, unbeknownst to the patient.[96] Even if a person confirms that their insurance will pay for treatment, out-of-coverage doctors may still participate without the patient's consent.[97] People were especially likely to receive a surprise bill after emergency services; consider Jennifer Boylan who—despite assurances of a nominal price based upon her insurance—was obligated to pay $145,000 for her child's delivery.[98] When a Philadelphia hospital flew a COVID-19 patient to a nearby facility, the trip produced a surprise bill of $52,000.[99] Lisa French was personally responsible for $229,000 instead of the $1,337 predicted by her doctor, as she "unknowingly had signed up to pay all charges related to the hospital's then-secretive 'chargemaster' price rates."[100] But hopefully the recently enacted No Surprises Act may lessen the frequency and magnitude of surprise bills.[101]

---

95. *See generally* Sarah Kliff, *The Problem Is the Prices*, VOX (Oct. 16, 2017, 8:00 AM), https://www.vox.com/policy-and-politics/2017/10/16/16357790/health-care-prices-problem [https://perma.cc/27E9-TQBF] (discussing the problems brought by surprise bills); Olga Khazan, *What Happens When You Don't Pay a Hospital Bill*, ATLANTIC (Aug. 29, 2019, 9:10 AM), https://www.theatlantic.com/health/archive/2019/08/medical-bill-debt-collection/596914/ [https://perma.cc/9XXC-3R2Q] (stating that one in six Americans received a surprise medical bill in 2017 after being treated in a hospital).

96. *See* Zack Cooper, Fiona Scott Morton & Nathan Shekita, *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. POL. ECON. 3626 (2020).

97. Elena Renken, *Study: 1 in 5 Patients Gets a Surprise Medical Bill After Surgery*, NPR (Feb. 11, 2020, 2:59 PM), https://www.npr.org/sections/health-shots/2020/02/11/804906330/study-1-in-5-patients-gets-a-surprise-medical-bill-after-surgery#:~:text=Surprise%20Billing%20Is%20As%20Common%20After%20Elective%20Surgery%20As%20In,bill%20post%2Dsurgery%20exceeds%20%242%2C000 [https://perma.cc/24ML-S5WU]; *see also* Sarah Kliff, *A $52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. TIMES (Oct. 22, 2021), https://www.nytimes.com/2020/10/13/upshot/coronavirus-surprise-medical-bills.html [https://perma.cc/AJ3M-NWLJ] (providing examples of surprise billing during the pandemic).

98. Jennifer Finney Boylan, *My $145,000 Surprise Medical Bill*, N.Y. TIMES (Feb. 19, 2020), https://www.nytimes.com/2020/02/19/opinion/surprise-medical-bill.html [https://perma.cc/WJ5L-MU7R]; *see also* Renken, *supra* note 97 ("Surprise bills are common after emergency care or nonsurgical hospital stays, when patients may not be able to choose health care providers covered by their insurance. (Twenty percent of inpatient admissions from the emergency department likely led to a surprise bill, a Health Affairs study found.) For elective surgeries, patients often have time to select in-network providers, but it didn't appear to make a difference. . . . The study found that most of the surprise bills come from either anesthesiologists or surgical assistants — who are typically not chosen by patients.").

99. Kliff, *supra* note 95.

100. Timothy Bella, *She Expected to Pay $1,337 for Surgery. She Was Billed $303,709.*, WASH. POST (May 19, 2022, 3:51 PM), https://www.washingtonpost.com/nation/2022/05/19/colorado-hospital-surgery-cost-french/ [https://perma.cc/H2CN-6H25].

101. *What Is a "Surprise Medical Bill" and What Should I Know About the No Surprises Act?*, CONSUMER FIN. PROT. BUREAU (Dec. 7, 2023), https://www.consumerfinance.gov/ask-cfpb/what-is-a-surprise-medical-bill-and-what-should-i-know-about-the-no-surprises-act-en-2123/ [https://perma.cc/VE5R-96HS].

Another consequence of opacity involves informational asymmetries: most patients lack knowledge about which procedures to buy, or at which prices, without the help of doctors who may encounter incentives to sell unnecessary treatments. For instance, when heart stents fell out of favor, the procedure was repurposed for leg pain.[102] To drum up business, doctors held free consultations at churches located in low-income communities.[103] Although "no evidence" suggests that this procedure benefits most recipients, doctors sold the surgery upon querying individuals about whether they had experienced leg pain.[104] An article found that "mostly minorities or people in low-income areas"—many of whom trusted the doctors because they met them at churches—"[got] these procedures."[105] But as a local leader recounted, "[w]e don't know the medical science . . . . We just wanted to serve our community and invite people into our church."[106] Furthermore, the *New York Times* found that the informational asymmetry brought by opacity "has allowed hospitals to tell patients that they are getting 'steep' discounts, while still charging them many times what a public program like Medicare is willing to pay."[107] The opacity in healthcare may, in essence, reduce quality. It is also notable that providers, doctors, and hospitals can implement ancillary ways of excluding competition.

B. Indirect Restraints of Trade

Providers may indirectly impede competition in the process of raising prices. Take an anti-steering agreement which prevents insurers from nudging patients toward cheaper or better hospitals.[108] When Home Depot asked Anthem to provide its employees with a low-cost policy, Anthem declined because it was obligated to use expensive providers.[109] Walmart was similarly unable to exclude low-quality options from a plan with Aetna, as "insurers told the giant retailer their contracts with certain health-care providers didn't allow them to filter out specific doctors or hospitals, even based solely on quality measures."[110] A related tool is the "all-or-nothing" clause whereby an insurer must cover all or none of a hospital's services,

---

102. MARTY MAKARY, THE PRICE WE PAY: WHAT BROKE AMERICAN HEALTH CARE—AND HOW TO FIX IT 2 (2019).

103. *Id.*

104. *Id.* at 5.

105. *Id.* at 9. "With every trip to a church health fair, we were saddened to see happy, grateful people, mostly African Americans, being fleeced by white physicians and their staff." *Id.* at 12.

106. *Id.* at 12.

107. Kliff & Katz, *supra* note 81.

108. Mathews, *supra* note 75.

109. *Id.*

110. *Id.*

pressuring the insurer into covering the hospital's full slate of procedures regardless of price or quality.[111]

Another tactic involves isolating competitors by refusing to deal with them or by striking exclusivity agreements with vertical partners. With the latter, contracts between providers and hospitals have required usage of each other's services on an exclusive basis to foreclose upstarts from the market.[112] A refusal to deal occurs when a hospital or provider denies rivals access to its facilities.[113] In either case, a hospital may preserve its market power by depriving competitors of payors, patients, or facilities.[114] This landscape has, as explained next, brought the ills of an uncompetitive market.

C. Anticompetitive Effects in Healthcare Markets

Due to insufficient competition, healthcare's prices have increased, quality has declined, and marginalized groups have disproportionally suffered. In terms of hospitals, mergers have been demonstrated to produce monopolies or oligopolies and, as a result, have raised hospital prices by about 12.5%.[115] Prices are especially likely to elevate when acquired hospitals were located within five miles of each other.[116] Even when geographically distinct hospitals merged, rates were shown to increase.[117] According to one study, the premium paid by consumers after a merger was $521 annually while healthcare wages declined by $638 per year.[118]

Mergers have also degraded quality.[119] According to the *New England Journal of Medicine*, hospital acquisitions since 2010 have not only raised

---

111. Alex Wood, *Hartford HealthCare Hit with Antitrust Suit*, YAHOO! NEWS (July 8, 2022), https://news.yahoo.com/hartford-healthcare-hit-antitrust-suit-150800366.html [https://perma.cc/7V6C-HB77] (discussing an antitrust lawsuit involving an all-or-nothing practice).

112. *See, e.g.*, Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I., 997 F. Supp. 2d 142, 152 (D.R.I. 2014) (asserting a refusal to deal).

113. *Id.*

114. *Id.* at 154.

115. Zach Cooper, Stuart V. Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51, 55 (2019).

116. Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733, 735 (2001) (describing competition as a "good predictor" of prices).

117. Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286, 289 (2019).

118. Daniel R. Arnold & Christopher M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages* 27 (RAND Health Care, Working Paper No. WR-A621-2, 2020).

119. Gerard F. Anderson, Peter Hussey & Varduhi Petrosyan, *It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 38 HEALTH AFFS. 87, 88–89 (2019) ("US per capita health spending was $9,892 in 2016. The US spending level was 25 percent higher than that of Switzerland ($7,919), the country with the next-highest expenditure per capita; 108 percent higher than that of neighboring Canada ($4,753); and 145 percent higher than the OECD median of $4,033. If the US had spent the same amount per capita as Switzerland on health care in 2016, the US

rates but also worsened patients' experiences.[120] Other scholars have found the same in that "increased market concentration is significantly associated with lower patient satisfaction."[121] In a case study of Albany, GA, quality eroded after mergers lessened competition[122] whereas a change in New York's scheme that boosted competition was shown to lower prices and improve quality.[123] When legislative reforms caused U.K. hospitals to face heightened competition, mortality rates improved.[124] Experts estimate that thirty percent of spending on U.S. healthcare entails waste rather than buying a better quality of care.[125]

From an international context, the quality of U.S. healthcare is worse and more expensive than that of similar nations which also do better jobs of insuring residents—though the ACA has effectively boosted rates of insurance since its enactment. An angioplasty in the United States exceeds $32,000 whereas the international average hovers around $6,000.[126] Essential treatments, hospital stays, pharmaceuticals, insurance plans, and outpatient practices are also costlier.[127] In fact, the United States spends

---

would have spent $630 billion less on health care. US health spending increased at a faster rate (2.8 percent) than the OECD median (2.6 percent) between 2000 and 2016, and per capita health spending in the US more than doubled, from $4,559 to $9,892. The US spent 17.2 percent of its GDP on health care in 2016, and the OECD median was 8.9 percent." (footnote omitted) (citations omitted)).

120. Nancy D. Beaulieu et al., *Changes in Quality of Care After Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51, 56 (2020).

121. Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, 77 MED. CARE RSCH. & REV. 538, 541 (2020).

122. Christopher Garmon & Laura Kmitch, Health Care Competition or Regulation: The Unusual Case of Albany Georgia (Sept. 30, 2017) (unpublished manuscript), https://ssrn.com/abstract=3048839 [https://perma.cc/BAD2-8G4F].

123. Jack Zwanziger & Cathleen Mooney, *Has Competition Lowered Hospital Prices?*, 42 INQUIRY 73, 74 (2005) ("In 1996, New York enacted new legislation that opened the market for hospital services to competition. The Health Care Reform Act of 1996 (HCRA) abandoned inpatient rate regulation and allowed all private payers to negotiate the prices they would pay to the state's hospitals. The primary objective of this legislation was to harness the power of competitive markets to increase the efficiency of New York hospitals.").

124. Zack Cooper, Stephen Gibbons, Simon Jones & Alistair McGuire, *Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms*, 121 ECON. J. F228 (2011).

125. Shrank et al., *supra* note 6, at 1501–03 (defining "waste" as "failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity").

126. Margot Sanger-Katz, *In the U.S., an Angioplasty Costs $32,000. Elsewhere? Maybe $6,400.*, N.Y. TIMES (Dec. 27, 2019), https://www.nytimes.com/2019/12/27/upshot/expensive-health-care-world-comparison.html [https://perma.cc/WE6V-5JEJ].

127. *Id.* ("For almost everything on the list, there is a large divergence between the United States and everyone else. Patients and insurance companies in the United States pay higher prices for medications, imaging tests, basic health visits and common operations."); Michael A Carrier, *Higher Drug Prices from Anticompetitive Conduct: Three Case Studies*, 39 J. LEGAL MED. 151 (2019); Kate Ho & Robin S. Lee, *Insurer Competition and Negotiated Hospital Prices* 5 (Nat'l Bureau of Econ. Rsch., Working Paper No. 19401, 2013) (finding that increased competition among insurers lowers prices); Laurence C. Baker, Kate Bundorf, Anne B. Royalty & Zachary Levin, *Physician Practice Competition*

fifty-four percent more on healthcare than any other country,[128] almost eighteen percent of the country's GDP.[129] While the United States' mortality rate was superior in the early 1980s, it has fallen below the world average.[130] Premature deaths have also increased in the United States,[131] making life expectancy lower than in other OECD countries.[132] The *Healthcare Quality and Access Index* ranked the United States last among comparable countries[133] while the *Commonwealth Fund* found that U.S. healthcare has been the worst among developed nations for twenty years.[134] A part of this metric is the United States' low rates of insurance, as Americans visit doctors less than similar nations.[135]

Perhaps more worrisome is the disproportionate costs levied on society's least powerful.[136] Healthcare is the primary cause of why Americans enter

and Prices Paid by Private Insurers for Office Visits, 312 JAMA 1653, 1654 (2014); Dylan Scott, *A CT Scan Costs $1,100 in the US — and $140 in Holland*, VOX (Dec. 17, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/17/21024614/us-health-care-costs-medical-prices [https://perma.cc/TA5B-66MB].

128. Julie Potyraj, *The Quality of US Healthcare Compared with the World*, AJMC (Feb. 11, 2016), https://www.ajmc.com/view/the-quality-of-us-healthcare-compared-with-the-world [https://perma.cc/MJS3-MK6B].

129. Yoni Blumberg, *Here's the Real Reason Health Care Costs So Much More in the US*, CNBC (Sept. 3, 2018, 11:08 AM), https://www.cnbc.com/2018/03/22/the-real-reason-medical-care-costs-so-much-more-in-the-us.html [https://perma.cc/92BE-GB5M].

130. Imani Telesford, Emma Wager, Krutika Amin & Cynthia Cox, *How Does the Quality of the U.S. Health System Compare to Other Countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Oct. 23, 2023), https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/#item-overall-age-adjusted-mortality-rate-per-100000-population-1980-2017 [https://perma.cc/4L2C-YGBU].

131. *Id.*

132. Roosa Tikkanen & Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, COMMONWEALTH FUND (Jan. 30, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019 [https://perma.cc/6NUH-RKDF].

133. *Id.*

134. Olga Khazan, *The 3 Reasons the U.S. Health-Care System Is the Worst*, ATLANTIC (June 22, 2018), https://www.theatlantic.com/health/archive/2018/06/the-3-reasons-the-us-healthcare-system-is-the-worst/563519/ [https://perma.cc/N7C7-RT35].

135. Tikkanen & Abrams, *supra* note 132.

136. *See* Vann R. Newkirk II, *The American Health-Care System Increases Income Inequality*, ATLANTIC (Jan. 19, 2018), https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/ [https://perma.cc/J6SZ-UT6Y] ("[H]ousehold spending on health care is a significant contributor to income inequality in the United States. It also indicates that medical expenses push millions of Americans below the federal poverty line, including 7 million people who make more than 150 percent of the poverty level. Four million of those Americans are pushed into the ranks of extreme poverty."); *see also* Caitlin Owens, *Poor People Spend More of Their Income on Health Care*, AXIOS (Apr. 12, 2019), https://www.axios.com/poor-people-1555014746-1ba76fe9-c81e-4307-843f-4726b2e52bcf.html [https://perma.cc/Y8FY-2L2C] (discussing the heavier burden levied on poorer individuals).

debt collections[137] as well as declare bankruptcy.[138] Between twenty-five percent and forty-four percent of people in the United States will forego medical care each year due to costs, which again disproportionately impact marginalized groups.[139] For instance, Black maternal mortality is "staggeringly higher" than mortality in white mothers in part due to supracompetitive prices charged for the healthcare those mothers need.[140] Scholars have observed that communities of color receive worse care and unevenly lack insurance, as "[t]here has never been any period in American history where the health of Blacks was equal to that of whites. Disparity is built into the system."[141]

In sum, the ACA was expected to promote insurance—and the law certainly did—but it has reduced competition in an already concentrated industry. The ACA has also seemed to ease the obstacles of anticompetitive conduct, resulting in opaque prices, surprise billing, and price discrimination. If these problems derive from coordinated acts among partners or perhaps even rivals, shouldn't antitrust intervene? After all, if some hospitals and providers refuse to compete over prices, why has antitrust remained idle?

III. THE LONGSTANDING FAILURE OF ANTITRUST IN HEALTHCARE MARKETS

Agreements among hospitals to forego transparent price competition have evaded antitrust scrutiny despite classically anticompetitive traits in healthcare such as high prices and low quality. This is partially due to a longstanding belief that competition would harm consumers of healthcare—contrary to antitrust's conventional theory that competition increases consumer welfare. In fact, some providers insist that transparent prices would encourage anticompetitive conduct by enabling them to collude

---

137. Newkirk, *supra* note 136.

138. Lorie Konish, *This Is the Real Reason Most Americans File for Bankruptcy*, CNBC (Feb. 11, 2019, 2:20 PM), https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html [https://perma.cc/ME8C-XG8N]; James E. Dalen, Editorial, *Only in America: Bankruptcy Due to Health Care Costs*, 122 AM. J. MED. 699 (2009).

139. Megan Leonhardt, *Nearly 1 in 4 Americans Are Skipping Medical Care Because of the Cost*, CNBC (Mar. 12, 2020, 10:12 AM), https://www.cnbc.com/2020/03/11/nearly-1-in-4-americans-are-skipping-medical-care-because-of-the-cost.html [https://perma.cc/MD9P-W6BK]; Bruce Japsen, *Poll: 44% of Americans Skip Doctor Visits Because of Cost*, FORBES (Mar. 26, 2018, 8:00 AM), https://www.forbes.com/sites/brucejapsen/2018/03/26/poll-44-of-americans-skip-doctor-visits-due-to-cost/?sh=7038e1336f57 [https://perma.cc/V324-6HDF].

140. Karen Hoffman Lent & Kenneth Schwartz, *The Antitrust and Antiracism Nexus*, N.Y.L.J., June 8, 2021, at *1.

141. Austin Frakt, *Bad Medicine: The Harm that Comes from Racism*, N.Y. TIMES (July 8, 2020), https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html [https://perma.cc/ZRT7-BRPM].

(even more). A consequence is that courts are said to have rejected claims in healthcare that would garner liability in any other industry.[142] This Part (A) reviews antitrust law, (B) traces antitrust's failures in healthcare, and then (C) explains the anticompetitive traits of the U.S. system.

A. The Evolution of Modern Antitrust, Briefly Explained

Modern antitrust's "consumer welfare" standard imposes liability in limited scenarios and seldom in healthcare.[143] To understand the restrained nature of enforcement, the Sherman Act's text and history are helpful tools. Congress in 1890 enacted an open-ended statute in the form of the Sherman Act to ban restraints of trade (Section 1) and monopolizations (Section 2).[144] Section 1 prohibits "every" trade restraint while Section 2 condemns the monopolization of "any" part of the market.[145] Per the Supreme Court, Congress codified such a vague statute so that courts could narrow antitrust's scope in the future.[146]

Given this freedom to interpret the Sherman Act, courts in the 1970s reformed antitrust law after criticisms surfaced that enforcement was actually harming competition.[147] The belief was that courts may condemn almost any contract or behavior due to the Act's vague text.[148] For instance, firms could ostensibly suffer antitrust's wrath by engaging in acts

142. Waller, *supra* note 23, at 665.

143. *See* Maurice E. Stucke, *Reconsidering Antitrust's Goals*, 53 B.C. L. REV. 551, 561 (2012) (reviewing the economic goals of antitrust).

144. As background, Section 1 differs from Section 2 in that the former involves agreements among at least two parties to exclude competition, whereas the latter concerns a singular party who has accrued market power based on an exclusionary act. *See* Standard Oil Co. v. United States, 283 U.S. 163, 169 (1931) ("Any agreement between competitors may be illegal if part of a larger plan to control interstate markets.").

145. 15 U.S.C. §§ 1–2.

146. Daniel A. Crane, *Antitrust Antitextualism*, 96 NOTRE DAME L. REV. 1205, 1206 (2021) ("It follows that the antitrust statutes are best understood as a legislative delegation to the courts to create an evolutionary and dynamic common law of competition. As the Supreme Court explained in its landmark *Leegin* decision on resale price maintenance, 'From the beginning the Court has treated the Sherman Act as a common-law statute. . . . Just as the common law adapts to modern understanding and greater experience, so too does the Sherman Act's prohibition on "restraint[s] of trade" evolve to meet the dynamics of present economic conditions.' In other words, the statutory texts disclose little of importance; the action is all in dynamic judicial interpretation." (alterations in original) (footnotes omitted)).

147. *See* Thomas C. Arthur, *Workable Antitrust Law: The Statutory Approach to Antitrust*, 62 TUL. L. REV. 1163, 1167 (1988) (describing antitrust's evolution based upon economic goals).

148. *See* Nat'l Soc'y of Pro. Eng'rs v. United States, 435 U.S. 679, 687–88 (1978) ("One problem presented by the language of § 1 of the Sherman Act is that it cannot mean what it says. The statute says that 'every' contract that restrains trade is unlawful. But, as Mr. Justice Brandeis perceptively noted, restraint is the very essence of every contract; read literally, § 1 would outlaw the entire body of private contract law. Yet it is that body of law that establishes the enforceability of commercial agreements and enables competitive markets—indeed, a competitive economy—to function effectively." (footnotes omitted)).

benefitting consumers when a social or political injury resulted.[149] Consumer welfare was supposedly languishing because companies feared competing "too hard."[150] This helped to inspire a belief that over-enforcement (a type I error) poses greater problems than allowing some anticompetitive acts to go unnoticed (a type II error).[151] To make enforcement more rigorous, courts declared that antitrust may only achieve economic goals for the benefit of consumers.[152] Under what is known as the "consumer welfare" standard,[153] lawsuits must now show that an act caused restricted output, high prices, diminished quality, or similar economic injury.[154]

To assess whether an exclusionary act has actually violated Section 1, courts apply the rule of reason or the per se illegal standard depending on the conduct's odds of harming welfare. Per se illegality is appropriate for a small list of activities like price fixing that almost always injure consumers; in this scenario, courts offer no way of justifying the restraint.[155] But since antitrust presumes that defendants are typically driven by efficiency,[156] most conduct receives scrutiny under the rule of reason, which searches for an

149. *See, e.g.*, Brown Shoe Co. v. United States, 370 U.S. 294, 344 (1962) ("But we cannot fail to recognize Congress' desire to promote competition through the protection of viable, small, locally owned businesses. Congress appreciated that occasional higher costs and prices might result from the maintenance of fragmented industries and markets.").

150. *See* Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters, 459 U.S. 519, 529 (1983) ("A literal reading of the [Sherman Act] is broad enough to encompass every harm that can be attributed directly or indirectly to the consequences of an antitrust violation.").

151. *See, e.g.*, N.M. Oncology & Hematology Consultants v. Presbyterian Healthcare Servs., 994 F.3d 1166, 1173–74 (10th Cir. 2021) ("Indeed, when it comes to enforcing unilateral anticompetitive conduct, there is a risk that over-enforcement could actually inhibit competition, 'since it may lessen the incentive for the monopolist' to invest in their business." (quoting Verizon Commc'ns Inc. v. Law Offs. of Curtis V. Trinko, LLP, 540 U.S. 398, 408 (2004))); Frank H. Easterbrook, *The Limits of Antitrust*, 63 TEX. L. REV. 1, 4 (1984) ("Antitrust is costly. The judges act with imperfect information about the effects of the practices at stake. The costs of action and information are the limits of antitrust. I ask in this essay how we should respond to these limits.").

152. *See* Reza Dibadj, *Saving Antitrust*, 75 U. COLO. L. REV. 745, 751–54 (2004) (describing the influence of the Chicago School in focusing antitrust based on economic goals).

153. *See* Energy Conversion Devices Liquidation Tr. v. Trina Solar Ltd., 833 F.3d 680, 685 (6th Cir. 2016) ("At their core, the antitrust laws are a 'consumer welfare prescription.'" (citing ROBERT BORK, THE ANTITRUST PARADOX 66 (1978))); HERBERT HOVENKAMP, THE ANTITRUST ENTERPRISE: PRINCIPLE AND EXECUTION 2 (1st paperback ed. 2008) (reciting that after antitrust's "counterrevolution of the 1970s and 1980s . . . [t]he only articulated goal of the antitrust laws is to benefit consumers, who are best off when markets are competitive").

154. *E.g.*, Deborah Heart & Lung Ctr. v. Penn Presbyterian Med. Ctr., No. 11–1290, 2011 WL 6935276, at *7 n.8 (D.N.J. Dec. 30, 2011) ("In all cases, the relevant question is instead whether there has been an adverse effect on price, output, quality, choice, or innovation in the market as a whole.").

155. *See, e.g.*, United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 221–22 (1940) (holding that price fixing is a per se illegal activity).

156. For instance, although an exclusive-dealing agreement between a farmer and dominant corn chip company for the supply of corn could raise barriers to entry for rival corn chip companies by making it harder to purchase corn, it can also help the dominant company to supply consumers with cheaper corn chips. The belief is that most types of agreements—especially ones between vertically integrated companies—tend to create efficiencies and thus benefit consumers.

act's efficiencies despite its anticompetitive effects.[157] The rule of reason avoids type I errors by generally assuming that conduct is *procompetitive*.[158] Since per se illegality finds an offense in every instance whereas the rule of reason absolves most defendants, antitrust cases tend to hinge on the level of scrutiny applied.[159] Section 2 employs a similar analysis as the rule of reason.[160]

The Clayton Act was enacted in 1917 because anticompetitive mergers had been evading enforcement.[161] Before the Clayton Act, rivals could lawfully merge instead of striking an exclusionary deal even though the two scenarios can achieve the same effects (e.g., rather than agreeing to fix prices, two competitors could become one company). As such, the Clayton Act bans mergers that "substantially . . . lessen competition, or . . . tend to create monopoly."[162] And while the agencies have seldom used the Sherman Act to initiate antitrust cases against hospitals and providers, they had long failed to win merger cases under the Clayton Act until more recently. The next Section traces the lack of (successful) antitrust cases in healthcare by delving into an astounding belief: patients benefit from uncompetitive markets.

B. The Failure of Antitrust Enforcement in Healthcare

Antitrust enforcement has yet to promote meaningful competition in healthcare for a combination of reasons. The obstacles include (1) a historical belief that doctors were immune from antitrust review, (2) repeated failures of enforcers to block hospital mergers, and (3) theories asserting that courts should avoid reviewing exclusionary acts in healthcare.

To begin, doctors had historically enjoyed antitrust immunity. The old rule until the Supreme Court reversed course in 1975 was that the "learned professions" were exempt from antitrust review.[163] Because this allowed doctors to essentially skirt scrutiny for over eighty years, anticompetitive

---

157. *See* John M. Newman, *Procompetitive Justifications in Antitrust Law*, 94 IND. L.J. 501, 506 (2019) (explaining the balancing of procompetitive justifications in the rule of reason).

158. Albert A. Foer, *The Political-Economic Nature of Antitrust*, 27 ST. LOUIS U. L.J. 331, 337–38 (1983) ("With only slight exaggeration, there is really only one thing one needs to know about the rule of reason: when the rule of reason is applied, the defendant virtually always wins."); *see also* Michael A. Carrier, *The Rule of Reason: An Empirical Update for the 21st Century*, 16 GEO. MASON L. REV. 827, 828 (2009) ("Courts dispose of 97% of cases at the first stage, on the grounds that there is no anticompetitive effect. They balance in only 2% of cases.").

159. Foer, *supra* note 158, at 337–38.

160. Day, *supra* note 26, at 1309.

161. Clayton Act § 7, 15 U.S.C. § 18.

162. *Id.*

163. Goldfarb v. Va. State Bar, 421 U.S. 773, 779 (1975) ("There has long been judicial recognition of a limited exclusion of 'learned professions' from the scope of the antitrust laws . . . .").

acts reportedly became the norm in U.S. healthcare.[164] Judges even absolved hospitals of liability after highlighting their non-profit statuses or describing them as "good citizens" who would hardly exploit their patients.[165] In few other markets have antitrust judges given such deference to defendants over the course of decades.

And now that healthcare implicates antitrust review, some observers insist that antitrust law should still avoid the industry because competition would increase prices, decrease quality, or otherwise harm consumers[166]—a contention in contrast to antitrust's view of almost any other market.[167] An explanation for this idiosyncratic approach is that hospitals might cut corners in pursuit of cost-conscious consumers.[168] Competition may also inefficiently raise care's quality by forcing hospitals to offer, and compete over, redundant services, a theory known as the medical-arms-race hypothesis.[169] As such, two of the three hospitals in Roanoke, VA, were allowed to merge because, as the court recited, "as a general rule hospital rates are lower, the fewer the number of hospitals in an area."[170] And since a monopolist can ostensibly offer better healthcare at cheaper prices, members of this industry have insisted that it should be self-regulated outside of antitrust's reach.[171]

Observers have also justified minimal antitrust enforcement by citing healthcare's complexity. A belief was that courts would struggle to discern

---

164. Roxane C. Busey, *A View from the Trenches: A Reply to Professor Waller's* How Much Health Care Antitrust Is Really Antitrust?, 48 LOY. U. CHI. L.J. 685 (2017) (explaining the effects of *Goldfarb* in bringing healthcare into antitrust's eye); *see also* Waller, *supra* note 23, at 654 (querying "What Do Doctors Not Get About Price Fixing?"). *See generally Goldfarb*, 421 U.S. 773.

165. *See* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997).

166. Waller, *supra* note 23, at 665–66 ("[K]ey health care antitrust issues enjoy a de facto exemption from the traditional antitrust doctrine. Despite a fairly faithful Supreme Court, the law just does not seem to stick, particularly in the lower courts, which time after time accept arguments and defenses that simply do not hold water in other contexts. . . . If the actual or perceived needs of the health care industry are to prevail over our national commitment to market competition then so be it. But such a dramatic shift should occur only if that decision is made in a fundamentally democratic and open fashion and not on the sly in the lower courts.").

167. *See* Thomas L. Gift, Richard Arnould & Larry DeBrock, *Is Healthy Competition Healthy? New Evidence of the Impact of Hospital Competition*, 39 INQUIRY 45 (2002).

168. *See* Waller, *supra* note 23, at 656 (citing FTC v. Ind. Fed'n of Dentists, 476 U.S. 447, 462–63 (1986)).

169. David Dranove, Mark Shanley & Carol Simon, *Is Hospital Competition Wasteful?*, 23 RAND J. ECON. 247, 247 (1992) ("According to the MAR hypothesis, hospitals compete by providing too many high-tech medical services. Duplication of capital-intensive services raises the costs of care. At the same time, unnecessary duplication of services may cause the quality of care to fall as providers fail to take advantage of scale and learning effects. A direct implication of the MAR hypothesis is that competition among hospitals is bad." (citation omitted)).

170. United States v. Carilion Health Sys., 707 F. Supp. 840, 846 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

171. Stavroulaki, *supra* note 19, at 179 ("While antitrust enforcers remain faithful to the dogma that quality will be the result of the economic process, medical professionals mainly believe that the medical process and not the competitive rivalry will lead to quality improvements.").

anticompetitive acts from procompetitive ones.[172] Predicting a merger's impact on consumers might especially pose challenges when hospitals come from disparate geographic areas[173] or industries (e.g., a hospital's purchase of a kidney dialysis center).[174] Judges have also remarked that they must apply murky antitrust principles to "one of the most complicated and volatile sectors of the national economy."[175] Allowing courts to fumble through healthcare cases may, as the argument goes, create type I errors that antitrust is structured to avoid.[176]

The most remarkable theory concerns opaque pricing: observers have claimed that transparency would incentivize price fixing.[177] Since firms must know each other's prices to collude, hospitals cannot ostensibly fix rates so long as prices remain secretive.[178] They insist that competition

---

172. *See* Paul Wong & Lawrence Wu, *Health Care Antitrust: Are Courts Adapting to a Complex and Dynamic Industry or Are They Making Exceptions?*, 48 LOY. U. CHI. L.J. 667, 672–73 (2017) ("To be clear, however, this Article does not argue that the complexity somehow leaves health care exempt from the 'background rules' that antitrust law is meant to provide. As Professor Waller rightly observes, an industry is not exempt from normal antitrust law simply on account of complexity, technology, or importance. Rather, complexity merely makes it difficult to assess from a macro perspective whether courts are uniformly applying antitrust law without knowing many more details about each case." (footnote omitted)).

173. *See* Thaddeus J. Lopatka, Note, *Cross-Market Mergers in Healthcare: Adapting Antitrust Regulation to Address a Growing Concern*, 102 CORNELL L. REV. 821 (2017).

174. *See* Julia Kapchinskiy, *The Duality of Provider and Payer in the Current Healthcare Landscape and Related Antitrust Implications*, 55 SAN DIEGO L. REV. 617, 618 (2018) ("What happens when a drugstore buys a health insurance company? A deal of this kind seemed unthinkable until retail pharmacy giant CVS stepped forward with a $69 billion offer to buy Aetna, one of the major players in the US health insurance market. The merger was announced in late 2017 and is expected to close in late 2018, subject to approval by shareholders of both companies and regulators. This deal, which further blurs the lines between 'traditionally separate spheres' of the healthcare industry, represents the increasingly popular effort to change the care delivery mechanisms and to make healthcare more available." (footnotes omitted)).

175. Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I., 311 F. Supp. 3d 468, 472 (D.R.I. 2018); *see also* Cascade Health Sols. v. PeaceHealth, 515 F.3d 883, 891 (9th Cir. 2008) ("The market for hospital services and medical care is complex.").

176. *See* Wong & Wu, *supra* note 172, at 679 (discussing the problems of healthcare's complexities).

177. Robert Graboyes & Jessica McBirney, *Curing High Healthcare Prices*, MERCATUS CTR. (Sept. 24, 2020), https://www.mercatus.org/students/economic-insights/expert-commentary/curing-high-healthcare-prices [https://perma.cc/3YZ4-NFKL] ("But with tacit collusion, there's no need for the competitors to communicate with one another because the publicly available price is itself the communication. . . . Tacit collusion requires three conditions: a small number of providers, a high level of difficulty for new providers to enter the markets (in other words, a barrier to entry), and mutual knowledge of competitors' prices.").

178. Robert F. Graboyes, *The Problem with Transparent Healthcare Prices*, INSIDESOURCES (Nov. 26, 2019), https://insidesources.com/the-problem-with-transparent-health-care-prices/ [https://perma.cc/MS8W-U9BA] ("Under the right circumstances, transparency facilitates tacit collusion by relieving competitors of fear of undercutting one another. Without transparency, Company A might fear that Company B is charging $1,000 for some service, leading A to offer the service for $950. If a government website shows that B charges $1,400, then A has no need to go much below $1,400, if at all.").

should still prompt hospitals to lower prices—but it's not clear why.[179] As for antitrust, opaque pricing in healthcare has yet to face meaningful challenges. In fact, when the state of Minnesota sought to increase transparency, the FTC argued that the law was "laudable" yet requiring health plans to reveal "sensitive information" about prices "may chill competition by facilitating or increasing the likelihood of unlawful collusion."[180] That said, a few non-healthcare cases have produced diverging precedents. In 2020, plaintiffs cited opacity in the European bond market to successfully argue that it enabled collusion and inflated prices.[181] But other courts have stated that opacity is efficient; in a different bond case, it was asserted that "the opaque functioning of the bond market is entirely rational because it satisfies customer demand."[182] One opinion recounted the testimony of Prof. Einer Elhauge who reassured the court that "the prices in this [bond] market are opaque, so firms cannot price coordinate, regardless of what they want."[183]

A related effect is that the agencies have largely avoided scrutinizing healthcare practices under the Sherman Act (as opposed to mergers under the Clayton Act). When the DOJ initiated an action against Charlotte-area hospitals in 2016, it presented the "rare" instance in which an agency pursued a hospital for a Section 1 or 2 violation.[184] But instead of scrutinizing a conduct unique to healthcare like opaque pricing, the lawsuit targeted an anti-steering clause found in many other industries.[185] Then in 2020, the DOJ intervened after oncology groups in Florida divided markets—a per se illegal act under the Sherman Act.[186] In that dispute, providers agreed that some of them would supply radiation treatments while others would only offer chemotherapy, dividing the market for each

179. *See id.*

180. FTC, Comment Letter on Amendments, *supra* note 17.

181. *In re* Eur. Gov't Bonds Antitrust Litig., No. 19 Civ. 2601, 2020 WL 4273811, at *16 (S.D.N.Y. July 23, 2020).

182. Intervest Fin. Servs., Inc. v. S.G. Cowen Sec. Corp., 206 F. Supp. 2d 702, 717 (E.D. Pa. 2002).

183. Castro v. Sanofi Pasteur Inc., 134 F. Supp. 3d 820, 839 (D.N.J. 2015).

184. At the time, the second in recent history. David Garcia, *U.S. Department of Justice Sues North Carolina Hospital System for Insisting on Anti-Steering Provisions in Insurance Reimbursement Contracts*, SHEPPARD MULLIN: ANTITRUST L. BLOG (June 15, 2016), https://www.antitrustlawblog.com/2016/06/articles/criminal-doj/u-s-department-of-justice-sues-north-carolina-hospital-system-for-insisting-on-anti-steering-provisions-in-insurance-reimbursement-contracts/ [https://perma.cc/6B3R-WN4H] ("The complaint is potentially significant for a number of reasons. First, it is a comparatively rare example of a federal antitrust agency claim directly against a healthcare provider that does not involve a challenge to a proposed merger or acquisition transaction.").

185. *See, e.g.*, Ohio v. Am. Express Co., 585 U.S. 529, 541–42 (2018) (reviewing American Express's use of anti-steering provisions).

186. Press Release, DOJ, Leading Cancer Treatment Center Admits to Antitrust Crime and Agrees to Pay $100 Million Criminal Penalty (Apr. 30, 2020), https://www.justice.gov/opa/pr/leading-cancer-treatment-center-admits-antitrust-crime-and-agrees-pay-100-million-criminal [https://perma.cc/8S7K-V7F5].

service.[187] But notably, enforcers have largely yet to target anticompetitive practices primarily found in healthcare such as opaque pricing.

That said, given the increasing concern for healthcare, the government has recently taken aim at opaque pricing via executive order. But as explained next, it should have little impact on transparency or prices.

C. Modern Efforts to Foster Transparency

Due to rising healthcare costs and opaque pricing, an Executive Order in 2019 sought to encourage transparency, though few commentators expect for it to benefit patients or consumers. Pursuant to the Order, the Department of Health and Human Services enacted a final rule going into effect in 2021 stipulating that providers must ex ante disclose certain prices on their chargemaster.[188] The hope was that consumers could comparison shop among hospitals based on market rates. Procedures covered by the Order include X-rays, cesarean sections, laboratory tests, and other common treatments.[189]

Predictably, the American Medical Association challenged the rule as a First Amendment violation as well as arbitrary and capricious.[190] The U.S. District Court for the District of Columbia disagreed, holding that the Order was proper and fell within the agency's scope.[191] It also found that the public display of prices—an alleged act of compelled commercial speech—complied with the First Amendment after applying intermediate scrutiny.[192]

Despite the potential for transparency, the rule has extinguished much hope for reform. A primary criticism is that the penalty for failing to comply with the Order is an about $300-per-day fine.[193] Given the billion-dollar budgets of most hospitals, a paltry fine would unlikely spur transparency.[194] Critics even claim that the low costs of non-compliance will inspire providers to resist transparency since it makes the rule transactional—

187. *Id.*

188. Press Release, U.S. Dep't of Health & Hum. Servs., Trump Administration Finalizes Rule Requiring Health Insurers to Disclose Price and Cost-Sharing Information (Oct. 29, 2020), https://www.hhs.gov/about/news/2020/10/29/trump-administration-finalizes-rule-requiring-health-insurers-disclose-price-and-cost-sharing.html [https://perma.cc/24NG-P8GD].

189. Tami Luhby, *Trump's Hospital Price Transparency Rule Is Now in Effect. Here's What That Means*, CNN (Jan. 4, 2021, 5:46 PM), https://www.cnn.com/2021/01/04/politics/hospital-price-transparency-trump-rule/index.html [https://perma.cc/49XV-35KQ].

190. Am. Hosp. Ass'n v. Azar, 468 F. Supp. 3d 372, 374 (D.D.C. 2020).

191. *Id.* at 396–97.

192. *Id.* at 395.

193. Stephanie Armour, *Trump Administration Price-Transparency Rule Covering Hospitals Upheld*, WALL ST. J. (June 23, 2020, 9:41 PM), https://www.wsj.com/articles/trump-administration-price-transparency-rule-covering-hospitals-upheld-11592945973 [https://perma.cc/7TKV-B23V].

194. *See* Freakonomics Radio, *How to Fix the Hot Mess of U.S. Healthcare*, FREAKONOMICS (Mar. 31, 2021), https://freakonomics.com/podcast/how-to-fix-the-hot-mess-of-u-s-healthcare-ep-456 [https://perma.cc/BCJ9-BRY4].

follow the rule or pay a nominal amount.[195] Hospitals must also consider whether it makes sense to incur the costs of gathering pricing information in a publicly searchable manner due to the minimal penalty for non-compliance.[196] Reports have determined that only about 5.6% of hospitals have so far abided by the rule.[197]

Another problem is that hospitals can abide by the rule's letter but not spirit by making prices impossible to find. According to the *Wall Street Journal*, some hospitals employ "special coding embedded on their websites" intended to "block[] [pricing] information from web searches."[198] By doing so, providers may technically comply with the rule without actually disclosing prices. For these reasons, few observers expect for the Order to achieve its purpose.

In sum, healthcare markets have largely escaped antitrust review due to a combination of the industry's complexity, historical quirks, and repeated failures to enjoin anticompetitive mergers. This has seemingly empowered providers to collaborate without fear of antitrust review. But does this landscape make sense? Part IV makes the case for antitrust's intervention.

IV. THE PROMISE OF HEALTHCARE ANTITRUST

Pricing opacity has generally evaded antitrust scrutiny. This is notable because a good's price in a competitive market should fall to its marginal cost of production, yet rival hospitals may charge substantially different rates for the same services. It would seem that opacity can effectively defeat market forces. In light of how healthcare is prone to concentration and its impact on people's lives, this Part argues that antitrust's treatment of healthcare and opaque pricing must undergo an overhaul. It finds that opaque pricing should sometimes be condemned even when an agreement isn't readily apparent. The analysis delves into a variety of opacity practices ranging from cultural business norms to hub-and-spoke agreements.

A. Healthcare's Pricing Opacity Is Anticompetitive

An agreement among competitors to conceal prices is, in many instances, akin to price fixing. Recall that antitrust employs various levels of scrutiny,

195. *Id.*

196. Armour, *supra* note 200.

197. SEMI-ANNUAL HOSPITAL PRICE TRANSPARENCY COMPLIANCE REPORT: JULY 2021, PATIENT RIGHTS ADVOCATE (2021), https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c225e1a54c0e42272fbf/1626456614723/PatientRightsAdvocate.org+Semi-Annual+Hospital+Compliance+Report.pdf [https://perma.cc/AM6X-BPCP].

198. Tom McGinty, Anna Wilde Mathews & Melanie Evans, *Hospitals Hide Pricing Data from Search Results*, WALL ST. J. (Mar. 22, 2021, 5:30 AM), https://www.wsj.com/articles/hospitals-hide-pricing-data-from-search-results-11616405402 [https://perma.cc/7L2G-VTXN].

depending on a conduct's chances of degrading consumer welfare relative to providing procompetitive efficiencies. But to warrant antitrust scrutiny in the first place, an act must be considered exclusionary as opposed to a valid form of competition; after all, antitrust refuses to review legitimate activities such as innovating a superior product or offering low prices that can similarly jettison rivals from a market. That said, antitrust courts have yet to assess healthcare's opacity as exclusionary—much less struggled with the level of scrutiny—and thus the initial step is to establish that antitrust should review the practice under the rule of reason.

1. It's Exclusionary

The rule of reason assesses most types of anticompetitive acts via price changes (or output), as most firms compete via lowering rates (generally by increasing output).[199] And since consumers prefer cheaper options, the belief is that competition should pressure rivals into lowering rates.[200] If two firms make widgets, the cheaper company is expected to trumpet its lower prices in hopes of attracting consumers; this should force more expensive firms to reduce their prices whereby all firms charge $10. When a good's price increases, it often reflects a quality improvement. In essence, firms compete by lowering prices or otherwise pricing goods at more efficient levels (i.e., offering more quality per dollar). But if two firms avoid lowering their prices by agreeing to sell widgets at $20/unit, antitrust condemns this arrangement because price fixing frustrates competition, creates deadweight loss, and harms consumers.[201]

Opacity can generate similar dangers as price fixing when it impedes the competitive utility of comparison shopping and thereby raises rates above competitive levels. For markets to operate efficiently, consumers must be able to contrast prices; if two firms agree to withhold pricing information, they could potentially raise rates to monopoly levels due to the inability of consumers to reference a competitor's prices. It seems that firms may resist competition by agreeing not to display rates, a state of affairs worsened by several factors such as (1) consumers' lack of comprehendible information about healthcare and its prices[202] and (2) the beneficiaries of healthcare

199. John B. Kirkwood & Robert H. Lande, *The Fundamental Goal of Antitrust: Protecting Consumers, Not Increasing Efficiency*, 84 NOTRE DAME L. REV. 191, 214 (2008) ("In declaring that failed predation enhances consumer welfare, moreover, the Court measured consumer welfare not by total surplus but by the level of prices in the market.").

200. *See* Neil W. Averitt & Robert H. Lande, *Consumer Sovereignty: A Unified Theory of Antitrust and Consumer Protection Law*, 65 ANTITRUST L.J. 713, 737 (1997) (discussing the competitive benefits of comparison shopping).

201. Texaco Inc. v. Dagher, 547 U.S. 1, 4 (2006) (explaining that price fixing is condemned as per se illegal).

202. *See infra* notes 233–34 and accompanying text.

aren't typically the payors. Thus, whereas sellers should naturally lower their prices to similar levels, the large variations of prices suggest that providers have laid waste to market forces. For example, treatment of chronic obstructive pulmonary disease costs $99,690 at the Bayonne Hospital Center, but "[l]ess than 30 miles away in the Bronx, N.Y., the Lincoln Medical and Mental Health Center charges only $7,044."[203] Yet in an efficient market, people *should* flock to low-priced options to force prices downward—as such, opaque pricing could suggest, in many instances, that firms have de facto colluded.

Antitrust may even *currently* crack down on healthcare's opacity, as companies in non-healthcare industries have suffered liability for suppressing pricing information. In 1999, the Supreme Court confirmed an antitrust offense when an organization of dentists prohibited its members from advertising discounts under the auspice of preventing false advertising.[204] To the Supreme Court, the information baked into advertising is an essential part of competition because it enables consumers to determine which products to buy, from whom, and at what prices—and thus an agreement to conceal discounts was potentially anticompetitive under the rule of reason for "restrict[ing] the supply of information."[205]

In another case, the Supreme Court applied the rule of reason to find that a (different) professional organization offended antitrust law by forbidding competitive bidding over its members' services. The organization sought to justify their rule by asserting that consumers would overvalue prices which, they claimed, would cause members to degrade services in trying to lower their rates. But to the Supreme Court, the "ban on competitive bidding prevents all customers from making price comparisons in the initial selection of an engineer" and thus "is nothing less than a frontal assault on the basic policy of the Sherman Act."[206] From a 2023 case out of the tech industry—*Epic Games, Inc. v. Apple Inc.*—the court insisted that a dominant firm can violate antitrust law by erecting "information barriers" if consumers couldn't discover cheaper alternatives.[207] To antitrust's leading treatise, "[t]he less information a consumer has about *relative* price and quality, the easier it is for market participants to charge supracompetitive

203. Jeffrey Young & Chris Kirkham, *Hospitals Prices No Longer Secret as New Data Reveals Bewildering System, Staggering Cost Differences*, HUFFPOST (Dec. 6, 2017), https://www.huffpost.com/entry/hospital-prices-cost-differences_n_3232678 [https://perma.cc/5A2Y-7C62].

204. Cal. Dental Ass'n v. FTC, 526 U.S. 756, 759 (1999) ("There are two issues in this case: whether the jurisdiction of the Federal Trade Commission extends to the California Dental Association (CDA), a nonprofit professional association, and whether a 'quick look' sufficed to justify finding that certain advertising restrictions adopted by the CDA violated the antitrust laws.").

205. *Id.* at 776.

206. Nat'l Soc'y of Pro. Eng'rs v. United States, 435 U.S. 679, 695 (1978).

207. Epic Games, Inc. v. Apple Inc., 559 F. Supp. 3d 898, 1031–32 (N.D. Cal. 2021), *aff'd in part*, *rev'd in part*, *and remanded*, 67 F.4th 946 (9th Cir. 2023).

prices."[208] The point is that concealing information and thereby preventing consumers from comparison shopping may rise to the level of anticompetitive under current precedent, though this framework has yet to be applied to healthcare's opacity.

Backing this Article's stance is research illustrating the anticompetitive effects in healthcare markets. Recall Section II.C about the decline of competition, increased prices, and eroded quality.[209] Prior research has indeed suggested that healthcare's pricing reflects a lack of sufficient competition, buoyed by exclusionary practices.[210] And while high prices are an expected result of uncompetitive markets, the wide array of healthcare rates suggests that opacity constitutes an independent factor. Supporting this stance is a seminal article about informational asymmetries in the printer market.[211] The authors found that firms can effectively obscure prices in markets where consumers lack adequate information, indicating that shrouded information may lead to both higher and unpredictable pricing; the parallels with healthcare are perhaps apparent where most consumers lack adequate information about pricing and quality to make efficient or even rational decisions.[212] In fact, this Article analyzes data in the Appendix on transparency among hospitals, which likewise suggests that opacity is most common in the least competitive healthcare markets—though, the quality of available data should caution readers against making an empirical conclusion.[213] In short, the Appendix's analysis scrutinizes data on whether a hospital complied with the Executive Order about transparency to explore whether it reduced competition. It thus doesn't appear like opacity is justified by procompetitive justifications but instead propelled by a lack of competition.

The inference is that antitrust law should begin to review healthcare's opacity—and perhaps the seeds are being sown. In January of 2024, a district court agreed with the FTC and temporarily blocked a merger based on a type of healthcare information. The dispute arose when IQVIA—an analytics company—sought to acquire one of the last digital advertising companies, DeepIntent, in the market for communicating directly to

---

208. *Id.* at 1055 (emphasis added) (quoting PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION § 2008c (5th ed. Supp. 2021)).

209. *See supra* Section II.C.

210. *See supra* Section II.C.

211. Xavier Gabaix & David Laibson, *Shrouded Attributes, Consumer Myopia, and Information Suppression in Competitive Markets*, 121 Q.J. ECON. 505 (2006).

212. *Id.* at 507–08 (explaining why firms can shroud prices where consumers are "myopic" and thus charge steeper rates while attracting consumers away from cheaper firms).

213. *See infra* Appendix.

healthcare professions.[214] At issue was that the merger would have enabled IQVIA to control the grand majority of information flowing to doctors and hospitals, allowing IQVIA to raise prices based on shrouding information.[215] While this case differs a bit from opaque pricing—as it involves how information is withheld before it reaches consumers—the FTC's involvement indicates that enforcers should start to recognize the competitive saliency of transparency in especially healthcare markets.

Even if courts liken opacity to similar anticompetitive practices, there is still the question of scrutiny. After all, accepting that opacity is exclusionary would ordinarily lead courts to apply a deferential standard known as the rule of reason. But perhaps courts could go a step further in some instances and employ a heightened standard, especially if hospitals or providers entered an express agreement to withhold prices, as explained next.

2. *It's Especially Problematic*

An opacity agreement among direct competitors could seemingly face a more stringent level of enforcement. Whereas most types of trade restraints are declared procompetitive after incurring the rule of reason, perhaps pricing opacity might sometimes warrant a heightened level of review. As background, antitrust courts may occasionally increase scrutiny by applying an abbreviated form of the rule of reason—known as the quick look—if a practice would significantly raise the chances of anticompetitive effects.[216] Per the Supreme Court, the quick look is proper when "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on

214. *See generally* Gursimrankaur Mehar & Mrinmay Dey, *US Judge Allows FTC to Temporarily Block IQVIA Acquisition of DeepIntent*, REUTERS (Jan. 2, 2024, 11:26 AM), https://www.reuters.com/markets/deals/us-judge-allows-ftc-temporarily-block-iqvia-acquisition-deepintent-2023-12-30/ [https://perma.cc/7UQF-ZKZ2].

215. *See* Ben Adams, *'Disappointed' IQVIA Hit by Judge's Decision to Uphold FTC's Block of Its DeepIntent Buyout*, FIERCE PHARMA (Dec. 30, 2023, 1:00 PM), https://www.fiercepharma.com/marketing/disappointed-iqvia-hit-judges-decision-uphold-ftcs-block-its-deepintent-buyout [https://perma.cc/2Q3S-MWCC] ("According to the official complaint filed by the FTC in 2023, the merger would result in a 'heightened motivation' for IQVIA to withhold critical information, hindering competition among rival companies and potential new entrants.").

216. *See generally* Edward Brunet, *Antitrust Summary Judgment and the Quick Look Approach*, 62 SMU L. REV. 493, 496 (2009) ("With this background of uncertainty regarding the use of summary judgment in antitrust litigation and the history of controversial application of the per se and rule of reason labels, the so-called quick look approach originated. Born in a series of briefs to the United States Supreme Court in the 1980s, the quick look methodology was essentially the effort of antitrust specialist litigators to articulate a sort of middle-ground, efficient way to avoid overly complex trials. The idea of the quick look might have evolved from Professor Phillip Areeda's observation that the rule of reason need not be overly lengthy and could be 'applied in the twinkling of [an] eye.'" (footnote omitted) (quoting PHILLIP AREEDA, THE "RULE OF REASON" IN ANTITRUST ANALYSIS: GENERAL ISSUES 38 (1981))).

customers and markets."[217] The quick look resembles the rule of reason but notably flips the burden: it presumes that conduct is anticompetitive.[218] As a result, this framework imposes liability unless the defendant can show that the loss of competition benefited consumers whereas the rule of reason seeks to avoid type I errors.[219]

So why should courts consider reviewing an opacity agreement under the quick look? To justify elevating scrutiny, key metrics in this instance include whether the market would likely self-correct or whether the defendant can cite procompetitive justifications. As such, pricing opacity in healthcare (1) is more harmful and robust than in mundane markets due to inelastic demand, natural concentration, and informational asymmetries; (2) would often establish supracompetitive rates akin to price fixing; (3) inflicts disproportional harms on society's least powerful; and (4) can rarely be expected to levy procompetitive efficiencies.

First off, healthcare's opacity poses graver dangers due to inelastic demand, information asymmetries, and natural concentration. In terms of inelasticity—a term referring to goods or services that consumers purchase at constant rates even when prices rise[220]—healthcare is considered an inelastic necessity, which incentivizes exclusionary practices.[221] This is because cartels in non-essential markets like baseball cards can only charge so much before marginal customers refuse to buy the good.[222] But in healthcare, treatment is frequently inelastic in that people would often agree

217. Cal. Dental Ass'n v. FTC, 526 U.S. 756, 770 (1999).

218. *In re* Ry. Indus. Employee No-Poach Antitrust Litig., 395 F. Supp. 3d 464, 480 (W.D. Pa. 2019) ("A *complete* rule of reason analysis in those circumstances is not always warranted; rather, a 'quick look' analysis may be conducted. The Third Circuit Court of Appeals has explained: 'A quick look "presum[es] competitive harm without detailed market analysis" because "the anticompetitive effects on markets and consumers are obvious."'" (quoting Lifewatch Servs. Inc. v. Highmark Inc., 902 F.3d 323, 336 n.8 (3d Cir. 2018))); *see* Andrew I. Gavil, *Moving Beyond Caricature and Characterization: The Modern Rule of Reason in Practice*, 85 S. CAL. L. REV. 733, 777 (2012) ("The defining characteristic of the quick look, however, is its ability to shift a burden from the plaintiffs to the defendants without 'elaborate industry analysis.'" (quoting Nat'l Soc'y of Pro. Eng'rs v. United States, 435 U.S. 679, 692 (1978))).

219. *See In re* Se. Milk Antitrust Litig., 739 F.3d 262, 274–75 (6th Cir. 2014) ("Applying this test is useful when the anticompetitive nature of an agreement is so blatant that a detailed review of the surrounding marketplace would be unnecessary.").

220. *See* Sean T. Murray, Note, *Comparative Approaches to the Regulation of Electromagnetic Fields in the Workplace*, 5 TRANSNAT'L L. & CONTEMP. PROBS. 177, 183 n.39 (1995) (explaining inelastic demand).

221. *See generally* Jahangir AM Khan & Rashidul Alam Mahumud, *Is Healthcare a 'Necessity' or 'Luxury'? An Empirical Evidence from Public and Private Sector Analyses of South-East Asian Countries?*, 5 HEALTH ECON. REV., December 2015, at 1.

222. Day, *supra* note 26, at 1323 (explaining the (in)ability of consumers to abandon monopolized markets and the potential implications for antitrust).

to pay any price for life-saving treatment so long as they can.[223] This allows monopolists to raise prices even higher than in nonessential markets, boosting the incentives to collude.[224] And since insurance pays (much of) the bill in many instances, it incentivizes people to agree to opaque pricing rather than seeking in vain for cheaper options. That said, since merger authorities consider elasticity to be a factor for whether to intervene pursuant to the Clayton Act, this could heighten enforcement under the Sherman Act.[225]

Another issue with opacity is that most patients lack information about which healthcare services to buy, much less at appropriate prices. An economic principle is that efficient markets require information that should flow under competitive conditions because firms encounter incentives to trumpet their goods' virtues or expose their competitors' follies.[226] But in healthcare, people must often rely on doctors for information about which services to buy and at what prices, creating conflicts of interest whereby a buyer's reliance on sellers can render predatory practices—for example, the repurposing of heart stents.[227]

Notice that anticompetitive acts in healthcare can inflict greater costs on marginalized people. For instance, uninsured people must often pay out-of-pocket costs and shoulder a greater burden of high prices. Since hospitals tend to be located in affluent areas, concentration has deprived marginalized areas of hospitals and doctors.[228] In addition, switching costs are heftier for uninsured people who are more likely to forego treatment due to monopoly rates.[229] Recall also that hospitals and providers, buoyed by opaque pricing,

---

223. *See generally* Martha B. Coven, *The Freedom to Spend: The Case for Cash-Based Public Assistance*, 86 MINN. L. REV. 847, 849 (2002); K. Sabeel Rahman, Essay, *Constructing Citizenship: Exclusion and Inclusion Through the Governance of Basic Necessities*, 118 COLUM. L. REV. 2447, 2448–49 (2018).

224. *See, e.g.*, FTC v. Vyera Pharms., LLC, 479 F. Supp. 3d 31, 38–40 (S.D.N.Y. 2020); Press Release, FTC, Six More States Join FTC and NY Attorney General's Case Against Vyera Pharmaceuticals, Martin Shkreli, and Other Defendants (Apr. 14, 2020), https://www.ftc.gov/news-events/press-releases/2020/04/six-more-states-join-ftc-ny-attorney-generals-case-against-vyera [https://perma.cc/P9LC-9SSB] (providing an example of prices increasing by over 4000% due to the necessity of the monopolized pharmaceutical).

225. DOJ & FTC, HORIZONTAL MERGER GUIDELINES 26 (2010), https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf [https://perma.cc/9HBW-VDGF].

226. *See* Gregory Day & Abbey Stemler, *Infracompetitive Privacy*, 105 IOWA L. REV. 61 (2019) (describing the role of information in markets).

227. *See* Iván Major, *Two-Sided Information Asymmetry in the Healthcare Industry*, 25 INT'L ADVANCES ECON. RSCH. 177, 178 (2019) (explaining informational asymmetries in healthcare); *supra* notes 102–07 and accompanying text.

228. Bennett Capers & Gregory Day, *Race-ing Antitrust*, 121 MICH. L. REV. 523, 535–36 (2023) (discussing the uneven effects of healthcare mergers in marginalized communities).

229. *Id.* at 527 ("By contrast, less well-off individuals—again, disproportionately people of color—are more likely to (1) forego healthcare due to monopoly rates, (2) sacrifice other necessities to do so, or (3) turn to self-medication." (footnote omitted)).

can charge uninsured people higher prices than they charge large insurers.[230] Since courts may define a market by whether a certain community has uniquely suffered anticompetitive effects,[231] the specialized harms on marginalized persons should militate toward the finding of an antitrust offense.

In fact, the cost on marginalized communities is the clearest sign of an antitrust violation. To conventional wings of antitrust, the hallmark of an offense is restricted output because it tends to create deadweight loss and raise prices (whereas high prices without restricted output may reflect a procompetitive dynamic such as improved quality).[232] In terms of healthcare, low-income persons have disproportionally tended to forego paying high prices whereas affluent individuals are more often insured or able to obtain credit, allowing them to acquire critical treatment.[233] So, as consumers refuse to buy a good due to monopoly prices, the lost transactions (or when people buy a poor substitute) as well as resources paid above competitive levels represent the sorts of deadweight loss condemned by traditional antitrust.[234] In this sense, the inability of low-income people to pay high prices constitutes restricted output and thus reflects a prime example of an antitrust violation.

A related frailty is that most healthcare markets can only support a handful of competitors in fostering collusion.[235] This is because it is easier to collaborate in concentrated markets due to a lack of collective-action problems; after all, if many firms formed a cartel, each one of them would face incentives to underprice their conspirators in order to usurp consumers, thereby causing the cartel to collapse.[236] But a cartel of two firms is more sustainable because conspirators can better monitor each other, keep a secret, and enforce their deal. The issue is thus that few firms compete in many healthcare markets—especially after the recent wave of mergers—

---

230. ROSENTHAL, *supra* note 37, at 31.

231. DOJ & FTC, *supra* note 232.

232. *See* Thomas B. Nachbar, *Qualitative Market Definition*, 109 VA. L. REV. 373, 393–402 (2023) (explaining why many scholars and courts consider output to be a superior metric of an antitrust offense than mere prices).

233. *See supra* notes 10–11 and accompanying text.

234. Day, *supra* note 26, at 1324–27 (explaining the role of deadweight loss from restricted output in formal models).

235. *See* JSW Steel (USA) Inc. v. Nucor Corp., 586 F. Supp. 3d 585, 596 (S.D. Tex. 2022) (remarking that market concentration is "conducive to collusion").

236. *See* Max Huffman, *The Necessity of Pleading Elements in Private Antitrust Conspiracy Claims*, 10 U. PA. J. BUS. & EMP. L. 627, 654 (2008) (explaining the increased chances of tacit collusion in an oligopoly).

and this lack of competition has bolstered prices due not only to natural monopolies, but also to opacity.[237]

Importantly, opaque pricing raises barriers to entry. Modern antitrust is based on conventional microeconomics that assumes high prices cannot alone create a violation because it should attract lower-priced rivals. In this scenario, an upstart is expected to undersell the monopolist and thus naturally lower prices.[238] But in a monopoly or oligopoly, the lack of pricing impedes upstarts who cannot as easily use the signal of low rates to attract consumers away from the dominant firm. Especially in a shadowy sector like healthcare, a new hospital would potentially struggle to convince patients of their cheaper prices if rival rates are hidden. While opacity would bear less of an impact in a competitive market, the practice may effectively erect barriers to entry in healthcare.

Opacity may also lack procompetitive justifications. A prominent theory is that transparency would allow firms to fix prices, but courts have generally refused to justify an exclusionary practice by the threat of a future anticompetitive conduct. Further, according to the Supreme Court in *National Society of Professional Engineers*, pricing collusion must be condemned even if it might ostensibly provide some benefits because it "is nothing less than a frontal assault on the basic policy of the Sherman Act."[239] In fact, given how healthcare markets are prone to anticompetitive practices—due to inelastic demand, informational asymmetries, and natural monopolies—the implication is that price collusion among vertically integrated partners is especially dangerous in justifying reliance on the quick look standard. Put differently, the presence of transparent prices might increase the ease of price manipulation but the remedy, as this Article

---

237. *See* Abelson, *supra* note 1 (explaining that hospitals have claimed that coordination among them would likely increase efficiency); Andrew Langer, *Hospital-Insurance Collusion Is the Real Driver of Rising Health Care Costs*, WASH. TIMES (July 4, 2020), https://www.washingtontimes.com/news/2020/jul/4/hospital-insurance-collusion-is-the-real-driver-of/ [https://perma.cc/M4GH-MVEJ] ("By colluding with hospitals and each other, large health insurance companies are engaging in the same price-fixing regarding physician and hospital prices. They first agree behind closed doors to excessively high hospital payments. This then leads them to artificially lower physician in-network rates. Ultimately, their end-goal becomes crystal clear: driving independent medical practices out of business.").

238. *See* Verizon Commc'ns Inc. v. Law Offs. of Curtis V. Trinko, LLP, 540 U.S. 398, 407 (2004) ("The mere possession of monopoly power, and the concomitant charging of monopoly prices, is not only not unlawful; it is an important element of the free-market system. The opportunity to charge monopoly prices—at least for a short period—is what attracts 'business acumen' in the first place; it induces risk taking that produces innovation and economic growth. To safeguard the incentive to innovate, the possession of monopoly power will not be found unlawful unless it is accompanied by an element of anticompetitive *conduct*.").

239. Nat'l Soc'y of Pro. Eng'rs v. United States, 435 U.S. 679, 695 (1978). Per the theory advanced by the organization, "competitive pressure to offer engineering services at the lowest possible price would adversely affect the quality of engineering. Moreover, the practice of awarding engineering contracts to the lowest bidder, regardless of quality, would be dangerous to the public health, safety, and welfare. For these reasons, the Society claimed that its Code of Ethics was not an 'unreasonable restraint of interstate trade or commerce.'" *Id.* at 685.

argues, is more antitrust enforcement, not less. In essence, opacity is not only unlikely to self-correct but also elevate dangers at least for express agreements. If a hospital is the only one in its market, its actions could still qualify as an effort to monopolize the market under Section 2 depending on the market's conditions.[240]

But reasons exist to caution against raising antitrust's stakes. One is that *more* hospitals, insurers, doctors, and providers are needed, yet increasing antitrust exposure could raise their costs and, as a result, diminish incentives to enter this market. And since healthcare is prone to concentration, a danger exists that a natural monopoly could be misinterpreted as anticompetitive. Further, a potential issue with reviewing opacity is that hospitals and providers describe their bargained rates as a competitive advantage; as such, condemning opacity might discourage hospitals from negotiating rates down. It is also likely true that transparency would solve collective action problems and thus help firms to price fix. But ultimately, this Article asserts that competition has so eroded in healthcare that resisting antitrust enforcement has partly created this problem. And while scrutinizing opacity may disincentivize hospitals from bargaining *and shrouding* prices, it is also this Article's position that market forces should naturally cause prices to converge on their (lower) marginal costs—which the current framework has certainly failed to do. If transparent pricing leads to de facto price fixing, then the answer should come from antitrust law as opposed to the de facto immunizing of opacity.

Nevertheless, this Article asserts that antitrust should not only scrutinize opaque pricing as exclusionary but, in many scenarios, do so as particularly suspect. There's also a host of complicating factors that may frustrate antitrust; indeed, not all instances of opaque pricing derive from an express agreement among competitors, which is discussed next.

3. *Other Anticompetitive Structures of Opacity Under Antitrust Law*

A muddying issue is that opaque pricing can arise from a multitude of ways, which antitrust may struggle to scrutinize. This Section delves into other arrangements such as when opaque pricing entails (1) an implicit culture of anticompetitiveness (rather than an express agreement) and (2) a hub-and-spoke agreement.

a. *Culture of Anticompetitiveness*

Potentially frustrating enforcement, a hospital could argue that opaque pricing is an industry norm rather than a restraint of trade. This is because

240. *See* 15 U.S.C. § 2.

an illegal restraint requires an agreement among two parties to eliminate competition rather than mere "parallel conduct," which concerns an implicit coordination of behaviors.[241] For instance, if one of the two gas stations in a town charges an extra dollar for gasoline, and the other gas station matches its high prices without an express agreement, this wouldn't ordinarily offend antitrust law; indeed, the defendants must have reached an actual promise.[242] The logic is textual because Section 1 of the Sherman Act pertains only to "contracts" and "combinations" in implying an agreement.[243] So what if opaque pricing appears more like a norm?

Since most parties who fix prices endeavor to keep their arrangements a secret, antitrust provides a route with circumstantial evidence. This involves showing that more than "conscious parallelism" drove an implicit agreement. To the Supreme Court, conscious parallelism is a "not in itself unlawful" behavior "by which firms in a concentrated market might in effect share monopoly power, setting their prices at a profit-maximizing, supracompetitive level by recognizing their shared economic interests."[244] A problem arises when implicit, "uncertain," or "ambiguous" signals of coordination are shared.[245] If one of the two gas stations in a town tells the other gas station that it "intends to raise our prices on Monday to $4.00/gallon," and then both gas stations do so, this might mimic coordinated behavior even though no formal agreement was struck.[246]

To show an illegal agreement without direct proof, parties can assert a tacit agreement using plus factors.[247] The complaint must indicate that "the defendants were not engaging merely in oligopolistic price maintenance or price leadership but rather in a collusive agreement to fix prices or otherwise restrain trade."[248] A primary factor suggesting more than conscious parallelism concerns the firms' "motive to enter a conspiracy, i.e., that 'the market is conducive to price fixing.'"[249] For example, courts emphasized whether a market's structure is concentrated and thus prone to

241. Bell Atl. Corp. v. Twombly, 550 U.S. 544, 552–53 (2007) (describing antitrust's treatment of parallelism).

242. *Id.* at 552.

243. 15 U.S.C. § 1.

244. Brooke Grp. Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209, 227 (1993).

245. *Id.* at 227–28.

246. William H. Page, *Tacit Agreement Under Section 1 of the Sherman Act*, 81 ANTITRUST L.J. 593, 609 (2017).

247. *Id.* at 607 ("A tacit agreement is better understood as one in which rivals communicate their intentions in language without forming a complete agreement, but then indicate their assent to the suggested course of action by subsequent interdependent pricing or other competitive actions.").

248. Parker Auto Body Inc v. State Farm Mut. Auto. Ins. Co., 171 F. Supp. 3d 1274, 1281 (M.D. Fla. 2016).

249. Valspar Corp. v. E.I. du Pont de Nemours & Co., 873 F.3d 185, 196–97 (3d Cir. 2017) (quoting *In re* Chocolate Confectionary Antitrust Litig., 801 F.3d 383, 398 (3d Cir. 2015)).

cartelization—for example, healthcare.[250] Another plus factor concerns whether the monopolized good's demand is inelastic, which again describes healthcare.[251] The overriding logic is that concentrated markets animated by high barriers to entry and inelastic demand make it easier for firms to agree or tacitly coordinate behaviors without attracting competition or allowing the market to correct—again, like healthcare.

In fact, courts search for acts that would otherwise make little sense in a competitive market, indicating that opaque pricing itself is a plus factor.[252] As a judge explained, it is important to assess whether the "defendants' behavior would not be reasonable or explicable (i.e. not in their legitimate economic self-interest) if they were not conspiring to fix prices or otherwise restrain trade—that is, that the defendants would not have acted as they did had they not been conspiring in restraint of trade."[253] Considering that prices should attract consumers and naturally converge on their marginal costs, the inference is that providers have collectively sought to avoid price competition.

Therefore, healthcare's structure should sometimes allow courts to infer an illegal agreement. After all, an overtly anticompetitive act such as the refusal to display prices seems only plausible in markets where collusion is easier to accomplish. When opaque pricing prevails among direct competitors, this appears tantamount to price fixing. But what about vertically integrated firms?

b. The Hub-and-Spoke Agreement

A hub-and-spoke agreement occurs when a party organizes a price-fixing scheme on different levels of the supply chain. For instance, an orange juice

---

250. *Id.* ("There is little doubt that this highly concentrated market for a commodity-like product with no viable substitutes and substantial barriers to entry was conducive to price fixing."); *see also* City of Tuscaloosa v. Harcros Chems., Inc., 877 F. Supp. 1504, 1513 (N.D. Ala. 1995), *aff'd in part*, *rev'd in part*, *and vacated in part*, 158 F.3d 548 (11th Cir. 1998).

251. *Harcros*, 877 F. Supp. at 1510 ("In an effort to prove their case plaintiffs have outlined seven structural conditions that facilitated the conspiracy: . . . 4) Inelastic demand for chlorine facilitates collusion . . . ."); *see also* Blomkest Fertilizer, Inc. v. Potash Corp. of Saskatchewan, 203 F.3d 1028, 1044 (8th Cir. 2000) (Gibson, J., dissenting) ("The purely situational factors in this case are the market structure and the crisis in the potash industry. The structure of the potash market was conducive to collusion, featuring an oligopoly, barriers to new sellers entering the market, inelastic demand, and a standardized product.").

252. Williamson Oil Co. v. Philip Morris USA, 346 F.3d 1287, 1301 (11th Cir. 2003) ("Although our caselaw has identified some specific plus factors, for example, 'a showing that the defendants' behavior would not be reasonable or explicable (i.e. not in their legitimate economic self-interest) if they were not conspiring to fix prices or otherwise restrain trade,' any showing by appellants that 'tend[s] to exclude the possibility of independent action' can qualify as a 'plus factor.'" (alteration in original) (citation omitted) (quoting *Harcros*, 158 F.3d at 572, 571 n.35)); *see also* Valspar Corp. v. E.I. du Pont de Nemours, 152 F. Supp. 3d 234, 241 (D. Del. 2016).

253. *Harcros*, 158 F.3d at 572.

company could arrange a price-fixing conspiracy carried out between orange growers. While it may appear like a vertical agreement between an input supplier and producer, a deeper dive could reveal common traits of price fixing, known as a hub-and-spoke agreement.

For instance, Apple orchestrated a hub-and-spoke agreement in the e-books market by convincing publishers to leave Amazon with the offer of higher prices.[254] When Amazon sued, Apple insisted that the rule of reason should apply because publishers are vertically integrated into Apple's market. Indeed, Apple and book publishers are partners in the supply of books instead of direct competitors. Albeit true, the court declared that the arrangement was per se illegal because it reflected a horizontal price-fixing scheme; after all, direct competitors—book publishers—entered an agreement to charge above-market prices.[255] Even though this arrangement was ostensibly struck between vertical partners, the effect was that Apple acted as the central organizer in helping horizontal competitors to fix prices.

With healthcare, enforcers could occasionally show a hub-and-spoke deal among hospitals, insurers, and/or providers. Recognizing the prevalence of pricing opacity, it would seem possible that a central actor has encouraged opaque pricing across a market. Whether this involves a hospital system endeavoring to cloak prices among contracting doctors or facilities, or a hospital system seeking to diminish competition among insurers, the ubiquity of opaque pricing suggests that a central orchestrator may sometimes exist rather than the product of numerous unique and independent decisions.

* * *

In sum, enforcers and courts have ignored anticompetitive practices in healthcare markets despite possibilities of price collusion. Although some providers have asserted that minimal competition tends to benefit consumers—especially in terms of pricing opacity—the evidence suggests otherwise. After all, prices should fall and converge around their marginal costs of production, yet healthcare is known for wildly diverging rates, high costs, and low quality. Even when horizontal competitors have seemingly engaged in parallel conduct, the nature of healthcare might generate enough

254. United States v. Apple, Inc., 791 F.3d 290, 296–97, 322 (2d Cir. 2015).

255. John B. Kirkwood, *Collusion to Control a Powerful Customer: Amazon, E-Books, and Antitrust Policy*, 69 U. MIA. L. REV. 1, 4 (2014) ("What united the critics was concern with Amazon's dominant position as an e-book retailer and its aggressive tactics, particularly its below-cost pricing as a seller and its hard bargaining as a buyer. Its low prices could drive out other booksellers and ultimately increase retail prices, while its buyer power could reduce gains to publishers and authors, stunting the development of new titles. One common refrain was that the government was focused on collusion by the publishers and Apple when the real problem was the threat of an Amazon monopoly.").

plus factors to harken antitrust liability. This approach would begin to redress the high costs of healthcare inflicted disproportionally on lower-income populations. Consider also an array of implications from this research.

B. Implications

Using antitrust's tools to scrutinize opaque pricing implicates a series of important issues. One of these is "*Parker* immunity," which allows states to suppress competition in healthcare and other markets. Other issues include access to healthcare and opacity in additional markets.

1. Parker Immunity

A pressing issue is whether antitrust courts should continue to exclude states from enforcement's scope. Recall that healthcare is a highly regulated industry via federal and state actors; while the industry is naturally prone to concentration, government has often enacted regulations meant to squelch competition implicitly and expressly. The optimistic theory of state antitrust immunity (also known as "*Parker* immunity") asserts that states are primarily expected to suppress competition when the public would benefit,[256] though it's increasingly apparent that states restrain trade to bestow monopoly profits on favored corporations.[257] And in few places is this clearer than healthcare, casting doubt on state action immunity.

For instance, the earlier discussion of COPAs traced how states privilege hospitals as the lone monopolist in certain regions. As the FTC and government enforcers complained, the restriction of competition raises prices and erodes care's quality as well as vests private hospitals with monopoly privileges that would otherwise offend antitrust law but for *Parker* immunity.[258] This has even spurred the FTC to investigate COPAs about potential remedies.[259] Far from a unique type of state-granted monopoly, Kentucky enacted "certificates of need" whereby a certain level of demand must be demonstrated for the state to permit a nursing facility.[260]

256. N.C. Dental State Bd. of Exam'rs v. FTC, 574 U.S. 494, 508 (2015) ("'[W]here the actor is a municipality, there is little or no danger that it is involved in a private price-fixing arrangement.' . . . [M]unicipalities are electorally accountable and lack the kind of private incentives characteristic of active participants in the market." (quoting Town of Hallie v. City of Eau Claire, 471 U.S. 34, 47 (1985))).

257. *See* Gregory Day, *Antitrust Federalism and the Prison-Industrial Complex*, 107 MINN. L. REV. 2193, 2194–95 (2023) (describing how states have vested monopoly rights in private corporations to extract supracompetitive revenue in particularly the prison-industrial context).

258. *See supra* notes 64–66 and accompanying text.

259. *See supra* notes 64–66 and accompanying text.

260. Garcia & Antel, *supra* note 64.

This restriction has reportedly suppressed competition as well as harmed insular communities who cannot meet the statutory threshold—specifically, Nepalese people in Kentucky asserted that their community was unable to establish a targeted facility due to this law exclusively.[261]

In addition, it is common for states to empower private actors such as doctors, dentists, and others to regulate their own industries and, predictably, limit competition.[262] While licensing agencies are justified on the grounds of health and safety, critics argue that their actual goal is, in many instances, to capture the industry and limit competition.[263] Given the ubiquity of licensing agencies in healthcare, the dangers are elevated.

So what is the logic of *Parker* in light of its harms? The Supreme Court instituted state action immunity on the grounds that states, as autonomous sovereigns, must occasionally suppress competition as ways of promoting the public's welfare and regulating local markets.[264] To the Court, states lack the same incentives to generate private wealth as non-state corporations.[265] After all, states are electorally accountable and should, as a result, resist imperiling their citizens and markets.[266] It was thus a mixture of public policy and federalism that led the Supreme Court to institute *Parker* immunity—despite no mention of states in the Sherman Act.

Healthcare, as this Article shows, creates tension with *Parker*'s wisdom. In many cases, the persons harmed by a state's anticompetitive practices come from vulnerable communities who can seldom use voting or political processes to remedy their injuries.[267] For instance, certificates of need have made it difficult for insular people to establish a nursing facility targeting their specific needs. The shrinking number of hospitals has especially injured people of color, as hospitals have disproportionally shuttered in low-

---

261. *Id.*

262. *See generally* Rebecca Haw Allensworth, *The New Antitrust Federalism*, 102 VA. L. REV. 1387, 1401 (2016) (explaining the anticompetitive potential of licensing agencies).

263. *See generally* Gregory Day, *Antitrust Federalism and the Prison-Industrial Complex*, 107 MINN. L. REV. 2193, 2197 (2023) (explaining the justification of state antitrust immunity).

264. Parker v. Brown, 317 U.S. 341, 351 (1943) ("In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.").

265. Town of Hallie v. City of Eau Claire, 471 U.S. 34, 47 (1985) ("Where the actor is a municipality, there is little or no danger that it is involved in a *private* price-fixing arrangement. The only real danger is that it will seek to further purely parochial public interests at the expense of more overriding state goals.").

266. N.C. State Bd. of Dental Exam'rs v. FTC, 574 U.S. 494, 508 (2015) (asserting that states are "electorally accountable and lack the kind of private incentives characteristic of active participants in the market").

267. Day, *supra* note 270, at 2197 ("[S]tates encounter powerful incentives to monopolize markets comprising marginalized communities due to their dearth of power—after all, inmates, immigrants, and others who lack resources or even the right to vote can seldom hold leaders accountable." (footnotes omitted)).

incomes regions.[268] In addition, the creation of hospital monopolies may unevenly benefit affluent populations living near mega-hospitals while depriving marginalized people of care.[269] Notice how healthcare defies *Parker*'s logic. Hardly immune to the goal of raising monopoly profits, the states' efforts to erode competition has transferred wealth to dominant companies. And the remedy of voting provides little relief to historically marginalized people who have seldom been able to employ the political process as a way of remedying grievances. While a goal of this Article is not to provide an extensive critique or overhaul of *Parker*—this task is done elsewhere[270]—it is worth understanding the role of states and *Parker* immunity in creating an inequitable landscape in healthcare and elsewhere.

2. *Access to Healthcare*

It is also critical to discuss access to healthcare. A heightened level of competition may not only lower prices and raise quality but also increase the rate of hospitals and providers across geographic regions. As mentioned earlier, the shrinking number of hospitals following mergers and other events has hardly affected populations equally. The reality has been that lower-income urban areas and rural regions are more likely to lose their medical facilities while affluent communities can more readily access care. Research has found that the further away one lives from a hospital—especially if a person lacks a car or convenient route via public transportation—the less likely one will visit a doctor, even during a potential emergency.[271] To this end, any measure reducing barriers to entry might increase the rate by which vulnerable communities receive care. And this increase of output would indeed achieve antitrust's goal.

For this reason, subjecting opaque pricing to antitrust review could improve equitable access to healthcare. Since new hospitals or providers appear less likely to challenge longstanding institutions or even monopolists—after all, an upstart can seldom engage in price competition against opaque pricing[272]—heightened transparency could incentivize hospitals and providers to break into uncompetitive, inefficient markets. The implication is that reforming antitrust law to scrutinize opaque pricing could help to democratize healthcare, an industry that has failed to serve people of color and marginalized communities since its inception.[273]

268. *See supra* notes 136–41 and accompanying text.
269. *See supra* notes 136–41 and accompanying text.
270. *See, e.g.*, Day, *supra* note 270.
271. *See supra* notes 10–11 and accompanying text.
272. *See supra* note 245 and accompanying text.
273. *See supra* notes 136–41 and accompanying text.

3. *Extension to Non-Health Care Markets*

Antitrust litigants have complained of opaque pricing in other markets known for concentration, secrecy, and collusion such as financial products—but their lawsuits have largely failed. Perhaps a reason for the difficulty of basing an antitrust lawsuit in opaque pricing concerns a lack of precedent. For a Section 1 or 2 lawsuit to be successful, the plaintiff must show an exclusionary act, often conceived as conduct that has unreasonably reduced competition. This means, for example, that running rivals out of business after developing a high-quality, low-priced product is not considered exclusionary because it reflects the essence of competition as opposed to "conduct without a legitimate business purpose."[274] A key issue in antitrust litigation is thus whether a challenged act can rightfully be described as exclusionary. In the small handful of disputes about opaque pricing, the courts have seemingly failed to grasp the anticompetitive nature of these agreements. In fact, recall that opacity agreements have been described as procompetitive.

As such, there is little reason why courts should not apply the above analysis to other industries where opacity frustrates competition. In fact, the lack of antitrust litigation in other opaque markets emphasizes the necessity of this theory. In addition to the bond market,[275] an example of a non-antitrust lawsuit contesting opacity has involved a "conspiracy" among companies in the business of short selling stocks who sought to prevent transparency and keep prices high.[276] Other markets[277] known for opacity include mortgages.[278]

That said, a novel type of antitrust dispute has recently sparked questions about transparent information. In *Epic Games v. Apple*, the judge during an early stage of litigation cited the competitive issues of Apple's cagey pricing as a potential antitrust problem.[279] Judge Smith wrote that intentionally depriving consumers of information about prices can bear the effect of

274. Merced Irrigation Dist. v. Barclays Bank PLC, 165 F. Supp. 3d 122, 142 (S.D.N.Y. 2016) (quoting *In re* Adderall XR Antitrust Litig., 754 F.3d 128, 133 (2d Cir. 2014)).

275. Intervest Fin. Servs., Inc. v. S.G. Cowen Sec. Corp., 206 F. Supp. 2d 702, 709 (E.D. Pa. 2002) ("In short, InterVest contends that as a participant in a conspiracy to maintain an opaque market and high spreads in the bond trading market, Bloomberg failed to provide the promised and necessary support to make the InterVest system a successful one.").

276. Iowa Pub. Emps.' Ret. Sys. v. Merrill Lynch, Pierce, Fenner & Smith Inc., 340 F. Supp. 3d 285, 337 (S.D.N.Y. 2018) ("[A] conspiracy is the only good explanation for why the stock loan market remains opaque.").

277. Castro v. Sanofi Pasteur Inc., 134 F. Supp. 3d 820, 839 (D.N.J. 2015).

278. Maxa v. Countrywide Loans, Inc., No. CV10–8076–PCT–NVW, 2010 WL 2836958, at *9 (D. Ariz. July 19, 2010).

279. Epic Games, Inc. v. Apple Inc., 559 F. Supp. 3d 898, 1031–32 (N.D. Cal. 2021), *aff'd in part*, *rev'd in part*, *and remanded*, 67 F.4th 946 (9th Cir. 2023).

defeating competition.[280] Important to this dicta was that the judge noted the importance of pricing in technology markets, given the ease by which platforms can shroud critical information. In essence, technological advancements may inspire courts and enforcers to recognize the anticompetitive effects of opaque pricing. The question is thus what antitrust standards or models should govern this dynamic. In short, one of the most pressing antitrust problems creating inequitable access to healthcare may soon become pervasive in disparate markets.

CONCLUSION

American healthcare has followed an idiosyncratic route in which most people receive insurance from their employers, leaving more individuals uninsured than in similar countries. This spurred Congress to enact the ACA to increase rates of insurance and bolster efficiency by incentivizing mergers among hospitals and providers. A prominent effect, though, is that few firms exist in many healthcare markets, easing the wheels of collusion. Opaque pricing is thus unsurprising.

While prices should be commonplace under competitive conditions, opacity in healthcare has yet to be considered an exclusionary act; as such, many hospitals and providers refuse to disclose prices before offering care. Without transparency, not only have prices climbed to supracompetitive levels but also downstream problems such as surprise billing and price discrimination have emerged. Partly explaining why antitrust courts and enforcers have yet to litigate opaque pricing as anticompetitive conduct, there was a historical belief that competition would—contrary to almost all other markets—harm healthcare markets and consumers. In fact, providers and observers claim that transparent prices would increase the odds of price fixing.

This Article argues that opaque pricing should, in many instances, be reviewed as anticompetitive. The analysis suggests that opacity impedes competition and, as a result, increases prices in similar ways to price fixing. But currently, courts and enforcers have yet to recognize opacity as exclusionary conduct. To make this case, the Article explains that opaque pricing in healthcare creates greater and more formidable barriers to entry than run of the mill restraints. Due to inelastic demand, informational asymmetries, and natural concentration levels, it is unlikely that these

280. *Id.* at 1056 ("Here, the information base is distinctly different. In retail brick-and-mortar stores, consumers do not lack knowledge of options. Technology platforms differ. Apple created a new and innovative platform which was also a black box. It enforced silence to control information and actively impede users from obtaining the knowledge to obtain digital goods on other platforms.").

markets will self-correct—this should perhaps, in some instances, negate antitrust's preference for the deferential rule of reason.

As such, this Article makes several arguments. The most important involves explaining that one of the most anomalous and common practices in U.S. healthcare is a reason for its waste and inequities. There is indeed little reason why U.S. healthcare must persist as one of the world's most costly, wasteful, and inefficient—a situation that has only been worsening. And rather than impacting consumers equally, this problem has given society's most vulnerable an outsized burden. Perhaps this state of affairs could begin to reverse course if antitrust enforcers, litigants, and courts took aim at pricing opacity.

APPENDIX

Empirically measuring the competitive effects of opacity poses issues because one must study the absence of a quality (e.g., prices). That said, the Executive Order in 2020 created a natural experiment about opacity's effects on competition and prices. After all, the Order forced hospitals to decide whether to list certain prices or incur a nominal fine, resulting in information about which factors lead hospitals to choose transparency or not.

One hypothesis is that opacity erodes competition. Under competitive conditions, the listing of prices should inspire rivals to lower their rates in vying for consumers. But in concentrated markets, the inability to undersell opaque pricing might impede new firms from entering the market because they would struggle to attract consumers away from dominant firms. Note that a degree of bidirectional causation seems to exist since a hospital can more easily mask prices due to a lack of collective action issues. After all, healthcare markets are prone to concentration, which may enable firms to collaborate pricing norms without a market correction; this issue could thus provide a topic of future research. That said, a potential implication is that providers of healthcare can more easily collaborate on opaque pricing.

This Article explores the hypothesis, though data limitations should caution readers against making any definitive conclusions. Hopefully, the initial analysis will spur others to collect more and better data that can produce both replicable and persuasive results. With that being said, the key independent variable, *Transparency*, comes from *Turquoise Health*, which measured a hospital's compliance with the Executive Order ranked from 1 (least transparent) to 5 (most transparent).[281] Next, the *Health Care Cost*

281. The following data comes from Turquoise Health and Health Care Cost Institute and is on file with author. The data can be requested at the following links: https://turquoise.health/researchers, https://healthcostinstitute.org/data.

Institute offers data about concentration in healthcare markets (for instance, Longview, TX or Miami, FL) as well as *Prices*, *Rates of Usage*, and *Per Person Spending*. In terms of *Concentration*, the *Health Care Cost Institute* calculated this dependent variable in an ordinal fashion—1 is not concentrated to 4 which is very highly concentrated—derived from the Herfindahl-Hirschman Index (HHI) which is antitrust's standard method of measuring competition in a market.[282] A larger HHI reflects a greater level of concentration whereas lower HHIs indicate more competition. Based on this data, the models take place on the hospital level: for almost one thousand hospitals located in big and smaller towns, the impact of transparency on concentration of each hospital's greater market is scrutinized.

In terms of the aforementioned limitations, the data canvasses only a select list of cities and towns. Further, the dataset is a snapshot of a single time period rather than a reflection of trends over time; and this is important, given the temporal fluctuations of prices, concentration, and other key variables. Even within cities and towns, the dataset spans a subset of hospitals, most of which are in big cities. While the dataset includes a significant amount of observations, one may question whether or not the set involves a random grouping. Due to these and additional issues, the hope is that others will uncover better data sources and methods to study opaque pricing.

This Article employs a type of model used in other articles assessing healthcare prices—a multivariate regression (ordinary least squares or OLS)—as well as supporting the results with a fixed effect analysis to control for whether *Per Person Spending* on healthcare influences concentration and prices (since prices may depend on spending habits in a locale).[283] Supplementing this analysis is data from the *U.S. Census Bureau* about *Population* sizes, *Median Income* of a city, Percentage of Populations *Older than 65*, and *Rate Without Insurance*.[284] See Table 1 for summary statistics.

282. *See generally Herfindahl-Hirschman Index*, DOJ ANTITRUST DIV. (Jan. 17, 2024), https://www.justice.gov/atr/herfindahl-hirschman-index [https://perma.cc/TJ8X-Q27N] (discussing HHI in antitrust enforcement).

283. *See generally* Gregory R. Day & W. Michael Schuster, *Patent Inequality*, 71 ALA. L. REV. 115, 140 (2019) (discussing the benefits of using a fixed effects analysis).

284. *QuickFacts*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/PST045223 [https://perma.cc/8ZE9-FTYC].

TABLE 1. SUMMARY STATISTICS

	Mean	Std. Dev.	Min	Max	Obs
Concentration	2.29	.987	1	4	1000
Transparency	3.64	1.45	1	5	1015
Population	624431	770171	11220	3900000	996
Usage Rate	.9762	.1638	.5362	1.413	1003
Age over 65	13.8	3.35	6	52.9	1003
Per Person Spending	4730	681.2	3025	7221	959
Rate Without Insurance	12.16	5.6	2.1	34.2	1003

The results show a statistically significant relationship between opacity and market concentration. While there is perhaps a reinforcing effect or endogeneity (simultaneity bias) among variables, a greater degree of opacity seems to bolster market concentration. Indeed, *Transparency*'s negative and statistically significant coefficient indicates an inverse relationship with concentrated markets, meaning that transparency is related to higher levels of competition. This was true in both the ordinary least squares analysis (Table 2) and the fixed effects regression controlling for *Per Person Spending* (Table 3).

TABLE 2. MULTIVARIATE REGRESSION

Dependent Variable: Concentration	Model 1	Model 2	Model 3
Transparency	-.0419**	-.041**	-.0418**
	(.0189)	(.0193)	(.0193)
Population	-.00000047***	-.0000004***	-.0000004***
	(.000000036)	(.00000004)	(.00000004)
Age over 65			-.0161*
			(.0084)
Rate Without Insurance	.0339***		
	(.0057)		
Usage Rate	1.113***	1.72***	1.711***
	(.194)	(.17)	(.17)
Constant	1.165***	.9809***	.7633***
	(.185)	(.1853)	(.2174)
R-Squared	0.2452***	0.2180***	.2209***
Observations	993	993	993

Prob > F *** = $p < 0.01$; ** = $p < 0.05$; * $p < 0.10$. Standard errors in parentheses.

TABLE 3. FIXED EFFECTS REGRESSION FOR PER PERSON SPENDING ON HEALTHCARE

Dependent Variable: Concentration			
	Model 4	Model 5	Model 6
Transparency	-.042***	-.042***	-.0406**
	(.0155)	(.0155)	(.0153)
Population	-.00000046***	-.00000048***	-.00000048***
	(.000000038)	(.000000037)	(.000000036)
Age over 65	.0181*		
	(.0079)		
Usage Rate	1.119***	1.196***	.734***
	(.1925)	(.193)	(.2107)
Rate Without Insurance			.0295***
			(.0058)
Constant	1.245***	1.499***	1.589***
	(.229)	(.2009)	(.1989)
R-squared	.2133***	.1996***	.2428***
Observations	955	955	955

Prob > F *** = $p < 0.01$; ** = $p < 0.05$; * $p < 0.10$. Standard errors in parentheses.

The analysis indicates that a hospital's level of transparency is linked to competition. Per each model, we can deduce on a statistically significant level that markets in which hospitals conceal prices bore the effect of impeding competition. In both the OLS and fixed effects models, the results remained the same. In fact, the analysis's statistical strength is perhaps attenuated due to data issues. While the dataset canvassed an array of cities and large towns, it omitted many of the most remote and concentrated areas in which there is only one hospital—or even no hospitals. An implication is that many of the most uncompetitive markets were omitted from the dataset.

With this preliminary analysis, opaque pricing seems ripe for antitrust review. It appears that courts and enforcers should often consider a heightened approach for when horizontal competitors enter an agreement to conceal pricing. After all, this Article suggests that rivals who collaborate over opaque prices have effectively defeated competition. Further, collusion is easiest to achieve in concentrated markets as seen with opaque pricing. An effect is that healthcare seems prone to market failure which threatens the affordability and availability of treatment. In important part, the consequences are far from randomly distributed, imposing uneven costs on uninsured persons and marginalized groups.