Like the captain of the Titanic, most of us have a difficult time believing anything could bring down our ship of state. But our rising health care costs, even though they have flattened out a bit over the past two years

could accept certiorari as early as next month, and end with some thoughts about health care reform and accountable care organizations.

II. Hospital Merger Enforcement

In the late 1990s, the Commission and the Department of Justice lost a string of challenges to hospital mergers in federal court, after which Justice got out of the business of hospital reviews entirely. But our concerns continued. In 2002, then-FTC Chairman Tim Muris announced that Commission economists would undertake a study of four consummated hospital mergers to determine whether they in fact resulted in higher prices or lower quality.

. A unanimous Commission found that prices for acute inpatient hospital services in the Evanston area had doubled and tripled post-merger, evidence that astounded us and reaffirmed our commitment to staying engaged.

Just after the Evanston decision, the Commission stopped what we believed to be an anticompetitive hospital merger in Northern Virginia, this one in 2008. In that case, the dominant hospital system in the region, Inova, tried to purchase the independent Prince William Hospital. After we filed suit, Inova abandoned the transaction. Prince William Hospital was concerned that without Inova, it would not be able to raise money for development. But as often happens when we challenge a transaction (in any industry), at the end of the day, Prince William found another suitor: a North Carolina hospital corporation that provided Prince William with an infusion of capital without posing competitive concerns.

In just the last 18 months, we have challenged three other hospital mergers.

Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court less than two percent of all hospital mergers over the last five years.

Our most recent case challenged OSF Healthcare Sys d Health System, a 3 to 2 merger in Rockford, Illinois. OSF would have controlled 64 percent of general acute-care inpatient services in the Rockford area post-acquisition and would have faced only one competitor. In November 2011, we went into federal court seeking a preliminary injunction, which we won just a few weeks ago. Shortly thereafter, the parties abandoned the transaction.

In another recent case we challenged a consummated 4 to 3 merger (except for obstetrical services, where it is 3 to 2) that we alleged would reduce competition and enable ProMedica to raise prices for general acute-care and inpatient obstetrical services. Last spring, we won a preliminary injunction from a federal

We do   t ask for certiorari every day. But here we believed, and the Solicitor General agreed, that the questions are so important that they warrant going to the Supreme Court. The questions extend beyond Albany, Georgia. As the SG explained to the Supreme Court in our cert. petition, the Phoebe case
authorities have asserted state action defenses to federal antitrust challenges.

Let me assure you: if this decision is permitted to stand, it will undermine the very basis of the state action doctrine, that is, the sensible notion that the antitrust laws should apply to the conduct of private businesses and individuals and not to government. And at least as importantly, it will drive up health care costs in Albany, Georgia, and create a roadmap for doing so elsewhere.

Nearly 70 years ago, in *Parker v. Brown*, the Supreme Court determined that the federal antitrust laws should not apply to states acting as sovereign. And in a line of cases since then, the Court has modestly expanded the state action doctrine to permit a state to delegate its authority to cities or even private concerns, but only so far as their actions are taken pursuant to a clearly articulated and expressed state policy to displace competition and the state itself actively supervises the conduct of private parties. That did not happen in Phoebe Putney, a decision that as it stands today is disturbingly, jarringly wrong.

IV. Health Care Reform and ACOs

Over the years, the FTC and DOJ have provided substantial constructive guidance to practitioners who want to work together, in the form of our Statements of Antitrust Enforcement Policy in Health Care, Guidelines for Collaborations Among Competitors, advisory opinions, and other outreach and informal consultations. Now, in its creation of ACOs, the Affordable Care Act gives incentives and permission to health care practitioners to join together in ways that may reduce costs and improve care. We have developed guidance here, too.

When we see gathering clouds of collaboration, as with ACOs, we understand that those do not always portend a dangerous storm. In fact, ACOs may offer hope for smooth sailing, not stormy weather. Just last Sunday, the *New York Times* reported that many experts believe the movement toward accountable care may be at least part of the reason for slower growth in health care spending over the past few years, the recession being the principal one.

We have all experienced the fragmented American health care system, where patients, or the patients relatives, have to convey the same information from one health care provider to the next, all the while trying to make sure that physicians do not prescribe conflicting treatment regimens or duplicative tests. ACOs can change that by getting many of the relevant providers for example, a primary care doctor, a cardiologist, a

preae s5170.9 T2 dnribagaBTf 0 1 system, wBT1 0 0 1 307.25 460..9 Tm0.9 T2 BT1 0 0 1 292.25 364.15(be)-50.9 T2 Ade SB

Interestingly, a short while ago, stakeholders were worried that the proposed CMS rules were so stringent that it was uncertain whether or not we would see any ACOs formed. The final CMS rules are not as onerous. It turns out that we will see ACO formation.

In fact, in the last six months, we have seen 65 CMS-approved ACOs. The 27 just approved this April already cover about 375,000 Medicare beneficiaries in 18 states across the United States and include more than 10,000 physicians, 10 hospitals, and 13 smaller physician-driven