Antitrust Enforcement in Health Care: Proscription, not Prescription

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long as those efforts do not result in the accumulation of market power.[1] For instance, in a number of advisory opinions, FTC staff has concluded that arrangements to improve quality and control costs through clinical integration are unlikely to violate the antitrust laws.[2] The passage of the Affordable Care Act (ACA) has not altered the antitrust standard that would apply to similar collaborations designed to reduce costs and improve the quality of health care.[3] Importantly, as Commissioner Brill recently noted, the ACA does not require providers to merge or consolidate and recognizes that ACOs may be formed through contractual arrangements that are well short of a merger.[4]

Collaboration designed to promote beneficial integrated care can benefit consumers. On the other hand, collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payers raises significant antitrust concerns. Antitrust concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty, whether that market is a cluster of hospital services or a single specialty, like cardiac care.

In every investigation of health care provider transactions, we carefully consider evidence that the transaction will benefit consumers through improved quality, new services and/or decreased costs. We expect and encourage parties to provide us with concrete evidence to support their quality claims. We work closely with experts in the field to assess the arguments made by providers about improvements to quality of care.

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[1] U.S. Dep't. of Justice & Fed. Trade Comm'n, Statements of Enforcement Policy in Health Care (1996), available at http://www.ftc.gov/sites/default/files/attachments/competition-policy-

We also recognize that providers want antitrust guidance to help them navigate the complex issues that arise in making business decisions in this evolving environment. In response, the Commission has undertaken a broad initiative to inform participants in health care markets about competition principles. Indeed, perhaps in no area of enforcement has the FTC provided as much detailed guidance as it has in health care. Consider the list: statements of enforcement policy such as the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (ACO Policy Statement);[5] seminal hearings and reports;[6] exc -0.0cemennkm4.32 Tngs ProgrSt j -0.0p Savi -0 0 8.

The Antitrust Treatment of ACOs and Other Health Care Collaborations

The antitrust laws treat collaborations among health care providers that are bona fide efforts to create legitimate, efficiency-enhancing joint ventures[10] differently from the way they treat price fixing schemes. As stated in the joint FTC and DOJ ACO Policy Statement:

> The antitrust laws treat naked price-fixing and market allocation agreements among competitors as per se illegal. Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration.[11]

The Commission asks several threshold questions when reviewing provider collaborations. Does the proposed arrangement offer the potential for pro-consumer cost savings or quality improvements in the provision of health care services? Is there bona fide integration or is this simply a mechanism to enhance leverage with payers through joint negotiation? Even if there is bona fide integration, are any price or other agreements among participants regarding the terms on which they will deal with health care insurers reasonably necessary to achieve the benefits of the collaboration? If the answer to these questions is "yes," then the collaboration is not considered a per se illegal agreement, but rather is evaluated under a rule of reason standard, which assesses whether the likely effect of the collaboration will be to benefit or harm competition and consumers.

The rule of reason analysis applied to provider collaborations generally follows the same framework contained in the Horizontal Merger Guidelines[12] defining relevant product and geographic markets, identifying market participants, calculating market shares and concentration, considering the likelihood of expansion by existing players or entry by new players and determining whether efficiencies will likely result. Because the collaboration does not result in the full integration of a merger, additional factors will be considered, including whether the individual members may continue to compete independently, and what other alternatives are available to customers of the joint venture. We also look at the purpose of the agreement, but I want to caution that even the best intentions will prove insufficient if the combination is likely to have anticompetitive consequences. Ultimately, we make a determination as to whether a particular agreement, on balance, benefits consumers or is likely to diminish quality, reduce output, or increase price.

Our analysis of ACOs is similar to our analysis of joint ventures in any market

information among ACO participants that threatens or leads to price-fixing or other collusion for competing services provided outside the ACO raises significant antitrust concerns

Based on information available from CMS, there are about 250 or 300 Medicare-based Shared Savings Program ACOs, and several hundred more commercial-only ACOs. Only two ACOs have requested antitrust review of their operations.[15] To date, the FTC has not opposed the formation of an ACO, or taken any enforcement action against an ACO. Nor have we received complaints that might warrant further inquiry. As a result, we are confident that antitrust concerns are not preventing the formation of beneficial ACOs. The FTC continues to work closely with CMS and DOJ to offer guidance and monitor the market for developments.

The Commission's enforcement actions against other provider collaborations provide further detail on how we analyze collaborations among health care providers.

Merger enforcement to prevent collaborations that create or enhance market power

Much has been written about the ongoing wave of provider consolidation in health care markets. A growing body of literature suggests that providers with significant market power can negotiate higher-than-competitive payment rates.[16] In a recent article, Professor Martin Gaynor, the current Director of the Bureau of Economics, points to economic research that shows that higher concentration in hospital markets leads to significantly higher prices.[17] Studies have shown price increases as high as 40% as a result of a system acquiring a competing hospital.[18] Professor Gaynor contends that because the United States has a market-based health care system, it is critical that health care markets are sufficiently competitive that firms have incentives to innovate and act as an effective vehicle for reform in it. He explains that as an antitrust enforcer, the FTC has an important role to play in preserving competition in markets where it exists today:

> The challenge of finding effective policies for dealing with highly concentrated markets underscores the importance of active antitrust enforcement. Preventing harmful consolidation ex ante is far more

[15] Fed. Trade Comm'n & U.S. Dept. of Justice,

effective at promoting efficiency and protecting consumers than is trying to deal with the consequences ex post, once it has occurred.[19]

In light of concerns about the potential anticompetitive consequences of provider consolidation, the FTC has acted to stop mergers where the evidence shows that they are likely to lead to higher prices or reduced quality. Beginning with the Evanston case in 2007, the FTC has successfully challenged three hospital mergers,[20] and a number of transactions have been abandoned after the FTC threatened a challenge.[21] Not surprisingly, many of our enforcement actions have concerned markets with a small number of providers. Areas where the number of providers decreases from 4-to-3, 3-to-2 and especially 2-to-1 are the most vulnerable to anticompetitive effects

The Commission's recent Sixth Circuit victory in *ProMedica* concerns the type of hospital transaction that creates antitrust problems. In the first appellate review in over 15 years of an FTC enforcement action against a hospital transaction, the Sixth Circuit upheld the Commission's decision to undo ProMedica Health System's acquisition of its rival, St. Luke's hospital.[22] The proposed merger would have given ProMedica, already the largest hospital system in the Toledo, Ohio area, more than half the market for general acute care hospital services and over 80% of the market for inpatient obstetrics services. The Sixth Circuit noted that in the Toledo market, a hospital's market share correlated closely with price, reflecting market power, but that price, at least in the case of ProMedica, did not correlate with higher quality. The court concluded that the high combined market shares, and St. Luke's location in the affluent southwestern Toledo suburbs, would have made ProMedica a "must have" for area insurers and left them with virtually no ability to walk away from the merged firm. Party documents supported this conclusion, including many indicating that St. Luke's management saw the acquisition leading to higher prices by increasing its "negotiating clout" over insurers.

The combination of physician practices was at issue in the Commission's and the State of Idaho's successful challenge to the acquisition by St. Luke's Health System of Saltzer Medical

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[19] Gaynor, *supra* note 17, at 3.

[20] Opinion of the Comm'n, In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, Aug. 6, 2007, *available at* http://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf; *ProMedica Health Sys. v. FTC*, 749 F.3d 559, 2014 WL 1584835, at 5 (6th Cir. Apr. 22, 2014); Fed. Trade Comm'n v. OSF Healthcare System & Rockford HealthCommd He0-4(H)1(eal)3(t)3(h)8(C)101(e(v)12(a)4(ns)9(s)-1(1)9(e)-8(s)10(/)7(23s)

Group in Nampa, Idaho.[23] St. Luke's, the state's dominant health system, had a large number of employed primary care physicians from prior acquisitions, including eight primary care physicians in Nampa. St Luke's acquired 16 primary care physicians practicing in Nampa from Saltzer. The Commission alleged that St. Luke's 80% post-acquisition market share gave it the ability to demand higher rates for adult primary care physician services in Nampa, Idaho's second-largest city. Although those prior acquisitions involving Nampa physicians gave St. Luke's greater bargaining power, payers had been able to resist at least some of St. Luke's demands because of the presence of an alternative provider, Saltzer. We alleged, and the Court agreed, that St. Luke's acquisition of Saltzer eliminated that remaining competitive option and would have led to higher prices for physicians services.[24]

I should note that management contracts whereby one hospital manages another hospital with which it also competes may raise concerns similar to horizontal acquisitions. These arrangements can be procompetitive if they create cost savings, quality improvements or other efficiencies. They could also be problematic, if a single entity negotiates price on behalf of both hospitals, or if the arrangement involves two of only a few competing hospitals in a market and enhances the likelihood of anticompetitive conduct. Although we have not challenged such conduct to date, we would take appropriate action if we find that such arrangements are likely to diminish competition.

Nevertheless, while we have been very concerned about certain collaborations, the Commission challenges very few provider collaborations. Over the last decade, we have challenged less than 1% of hospital deals, and we brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition.[27] Similarly, we have brought only three challenges to physician combinations,[28] though we continue to investigate such transactions on a regular basis as well.

For every transaction that we challenge, there are many more that we determine do not warrant a challenge. In most cases, we do not make public our decisions not to take action against a particular arrangement because of confidentiality concerns. We recognize, however, that it is helpful for the public to understand the facts and reasoning that led us to close an investigation. Where possible, the Commission issues closing statements to explain the basis for its decision.[29] We also use opportunities, such as this speech, to explain our decision-making.

Often, the competitive analysis reveals that the transaction would eliminate only limited competition. For example, staff originally had concerns about a proposed merger of a large medical center and a community hospital 40 miles away, based on initial indications that the

Specifically, the medical center was operating near full capacity, and thus often declined transfers from other hospitals and did not actively seek new patients through price competition. Moreover, the hospitals had previously entered into a collaborative relationship: the medical center's surgeons performed cardiac surgery at the community hospital as part of a program to address capacity constraints at the medical center and provide high-quality care locally at lower costs.

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What Counts as an Efficiency Claim?

When assessing a transaction's likely competitive effect, we worry about market-power because that is the source of the power to raise prices—but also analyze efficiencies. Merging hospitals often claim their combination will produce significant efficiencies, such as improved quality of care, avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs. Efficiencies may enhance a merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.

Under the Horizontal Merger Guidelines, efficiencies must meet several criteria to be credited.[34] First, they must be merger-specific in that they could not likely be accomplished in the absence of the merger. Second, they must not be vague or speculative. Finally, they must be cognizable, by which we mean the efficiencies are verified and do not arise from anticompetitive reductions in output. If merger-specific, cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive, the Commission is unlikely to challenge the transaction.

In assessing quality arguments, we examine a variety of evidence. We look at the comparative quality of the hospitals merging. If the acquired hospital already has strong quality measurements comparable to those of the acquiring hospital, we may question the ability of the acquiring hospital to improve those metrics. If the acquiring hospital has made prior acquisitions, we will want to see whether those mergers resulted in quality improvements. The parties must explain more than just the processes and practices that the acquiring hospital system can transfer to an additional hospital; they need to address the specifics of how those processes and practices will benefit patients through improved care. In addition, we also want to understand why the acquired hospital could not improve its quality without a merger with this particular acquirer. Ultimately, given that competition spurs competitors to innovate, we will want to understand why a reduction in competition will enhance rather than diminish those incentives.

Another question sometimes raised is how we balance the possibility and magnitude of a price increase against the possibility and magnitude of efficiencies. In cases where the parties argue that efficiencies will lower costs, we can predict the likely overall effect of a transaction on prices. However, it is more difficult to determine how best to balance a possible price increase on the one hand and a quality improvement on the other hand. To date, however, that is not something we have found necessary to do. In the handful of transactions we have challenged, we have determined that the quality improvements were speculative, not substantiated, and/or the merger was not necessary to achieve them.

Foundations and Certificates of Need, Conn. Pub. Act No. 14-168 (Effective Oct. 1, 2014). According to the Bill Summary, the Attorney General must maintain and use the information submitted to him as part of his antitrust investigation and enforcement capability, available at http://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=35&which_year=2014

[34] HMG § 10.

Efficiencies analysis was a key issue in the FTC's recent challenge to St. Luke's acquisition of 41-member Saltzer Medical Group. The parties claimed that the acquisition was necessary to advance their effort to transform health care from a fragmented, fee-for-service model that rewards providers based on volume, to a financially and clinically integrated, risk-based system rewarding successful patient outcomes. Such a system could only succeed, they claimed, if the hospital employed a critical mass of doctors.

While we recognized the benefits of coordination and the efficiencies it could generate, there was no persuasive evidence that a merger was needed to generate those efficiencies. As we argued at trial, the evidence did not show that employing physicians is necessary to achieving integrated care.[35] For example, shared access to electronic medical records that St. Luke's cited as a central benefit of the transaction can be achieved without an employment relationship or merger. In fact, as the trial got underway, St. Luke's itself was in the process of developing and implementing a program providing non-affiliated physicians access to its EMR system. And there are many different ways, short of consolidation, for hospitals to ensure that independent physician practices are aligned with the hospital's aims, including patient protocols and financial incentives for meeting specified quality goals.

After 34 days of trial, the federal district court in Boise held that St. Luke's acquisition of Saltzer would substantially lessen competition and ordered a divestiture. While the court acknowledged that moving toward more integrated care and the greater use of electronic medical records can improve patient outcomes, it found that those goals could be achieved in ways other than the acquisition of a physician practice group which created a substantial risk of higher prices. The court emphasized: "St. Luke's is to be applauded for its efforts to improve the delivery of health care in Treasure Valley. But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs."[36]

What Counts as a Failing Firm/Financial Health Claim?

In addition to efficiencies defenses, parties often raise failing firm arguments. Specifically, they argue that an acquired hospital is experiencing financial difficulties and its acquisition by a financially stronger hospital is necessary to keep it open. Under the Merger Guidelines, a company can assert what is known as a "failing firm" defense only if (i) the company is unable to meet its obligations as they come due; (ii) would not be able to organize successfully in bankruptcy; and (iii) it has made unsuccessful good faith efforts to elicit reasonable alternative offers that would keep its assets in the relevant market and pose a less

[35] St. Luke's Health Sys., 1:13-CV-00116-BLW, Plaintiffs' Amended Corrected Proposed Facts and Conclusions of Law, 72 –123.

[36] St. Luke's Health Sys., 1:13-CV-00116-BLW, Memorandum Decision and Order at 3 (Jan. 24, 2014). On March 4, 2014, St. Luke's and Saltzer appealed the court's order to unwind the existing relationship and requested a stay pending the appeal.

severe danger to competition than does the proposed merger.[37]

anticompetitive effect. For example, t

way in which it should make capital improvements, and the like. Yet a remedy focused only on price risks denying consumers the benefits of non-price competition.[44]

Conclusion

We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. The antitrust laws have stood the test of time precisely because they do not mandate any particular behavior or way of doing business. Stated simply, there is no "approved way" to compete. Conversely, there is no laundry list of infractions that could automatically undermine a business arrangement. Congress specifically rejected the idea of creating a list of business "don'ts," opting for general language that would develop in the common law tradition. The wisdom and foresight of this approach can be seen in the myriad ways the antitrust laws have adapted to changes throughout the American economy for more than 100 years. The antitrust laws do not prescribe certain behavior or business models; rather, the antitrust laws proscribe behavior that, on the whole, reduces consumer welfare.

In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws. For those involved in an existing ACO, or those interested in joining one, there are many lessons to be gleaned from the FTC's competition work in health care markets, including those in which the agency determined not to take action. Coupled with other forms of guidance, there can be little doubt that FTC enforcement in health care markets is intended to promote competition as a primary driver to hold down costs, improve quality, and encourage innovation while allowing procompetitive ventures that do not harm consumers to proceed.

[44] While some state Attorneys General have accepted conduct-based remedies in a handful of cases, states often have robust state regulatory bodies, with particularized knowledge of the community needs, that may put them in a better position to overio9.4